BUILDING AN AMERICAN HEALTH SYSTEM: JOURNEY TOWARD A HEALTHY AND CARING AMERICA

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

NOVEMBER 9, 1989

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BUILDING AN AMERICAN HEALTH SYSTEM: JOURNEY TOWARD A HEALTHY AND CARING AMERICA

THURSDAY, NOVEMBER 9, 1989

U.S. House of Representatives,
Select Committee on Aging,
Washington, DC

The Committee met, pursuant to notice at 9:30 a.m., in Room 345, Cannon House Office Building, Honorable Edward R. Roybal (Chairman of the Committee) presiding.

Members present: Representatives Roybal, Wise, Bilbray, DeFazio, Schneider, Snowe, Boehlert, Bentley, Meyers, Schuette, Morella, Duncan and James.

Staff present: Manuel R. Miranda, Staff Director; Richard A. Veloz, Professional Staff; Gary Christopherson, Director of Health Legislation; Yvonne Santa Anna, Professional Staff; Valerie Batza, Executive Assistant; Carolyn Griffith, Staff Assistant; and Diana Jones, Staff Assistant.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Mr. Roybal. The Committee will now come to order. First of all, I'd like to have the witnesses come and sit at the table—Messrs. Rogers, Fraser, Steelman, Scott.

The purpose of today's hearing is to examine proposals for comprehensive reform of health and long term care in America and to assess their potential for alleviating the Nation's costs, quality and access problems and for building an American health system.

We are here today to help move forward an agenda of providing affordable and quality protection to the many millions of uninsured and underinsured Americans. One of the many vehicles that can be used to accomplish this is a bill that I have introduced, H.R. 2980, which is called the "USHealth Act."

As compared to a few years ago, we have several comprehensive reform options available for consideration. My bill is not the only one. There are several others. Several of these options will be presented by today's witnesses. In choosing among these options, I believe certain criteria should be applied. We must know, first of all, if the uninsured are fully insured. Are the underinsured insured for basic health care? Are they insured for catastrophic acute care? For catastrophic long term care?

We must know also if in those proposals we find that the quality of health care is assured for everyone. And then comes the $64,000 question. How is it going to be financed? Are the costs involved affordable for individuals? Is it affordable to the government? To the employers throughout the country? Are they all going to participate in making possible this national health plan so that everyone participates and everyone receives? Is that a possibility?

I believe that it is. I believe that the American people are depending on the Congress of the United States, and on the leadership of this country, to look into this problem and come up with ways and means of solving the situation.

Fortunately, as I said before, there is no shortage of options for dealing with these broad and tragic problems. It is also important to remember that all of these options get their funding from the same source, the pockets of the American people.

A criteria for selecting a solution should be solely on what is the most effective and efficient way to use the American people's dollars to meet the American people's health and long term care needs. That is what this hearing is all about. We hope to get answers to a lot of these questions. It is the intention of this Committee to take all of these very valuable recommendations, put them together in one particular package and, perhaps, come up with one bill that can be introduced.

In order to do that, we need the help of experts. We have invited experts in the field to come before us today. We also need health professionals. We need the medical profession. We need those who have trained for many years to become providers, and those who are involved in general health as a whole. We need that kind of input, so that when something is finally passed by the Congress of the United States, it will come from the thinking of the American people, and it will have strong support. Anything that has strong support can be successful.

Ladies and gentlemen, we are going to start by asking the Members who are here to make an opening statement. Mr. Schuette, you are now recognized.

[The prepared statement of Chairman Roybal follows:]

STATEMENT
FOR THE RECORD

EDWARD R. ROYBAL, CHAIRMAN
House Select Committee on Aging

"BUILDING AN AMERICAN HEALTH SYSTEM -- JOURNEY TOWARD A HEALTHY AND CARING AMERICA"

9:30 a.m., November 9, 1989
Room 345, Cannon House Office Building, Washington, D.C.

The purpose of today's hearing is to examine proposals for comprehensive reform of health and long term care in America and to assess their potential for alleviating the nation's cost, quality and access problems and for building an American health system.

Today we are here to help move forward an agenda of providing affordable and quality protection to the many millions of uninsured and underinsured Americans. One of the many vehicles that can be used to accomplish this is my national health plan proposal, the "USHealth Act" (H.R. 2980).

As compared to just a few years ago, we fortunately have several comprehensive reform options available for consideration. Several of these options will be presented by today's witnesses. In choosing among these options, I believe that certain criteria should be applied:

- Are the uninsured fully insured?
- Are the underinsured insured for basic health care?
- Are the underinsured insured for catastrophic acute care?
- Are the underinsured insured for catastrophic long term care?
- Is the quality of health care assured for everyone?
- Are costs affordable for individuals, government and employers?

In my view, Congress and the Administration cannot meet its responsibility to the American people with anything less than a comprehensive plan. Not just for the poor or the rich or the elderly, it must provide comprehensive protection for all Americans. Not just physician and hospital care, it must provide comprehensive health and long term care. Not just for certain States, it must provide comprehensive nationwide protection.

Though some argue for piece-at-a-time solutions to these problems, Congress should support a comprehensive solution. The Medicare Catastrophic Coverage Act is one example of a piecemeal approach. The failure of either business or government by itself to contain health care costs is another argument against piecemeal approaches.

It is my opinion that we should expand Medicare to provide basic health and long term care benefits for all Americans, regardless of age or income. We should cover primary, acute and long term care with special safeguards for catastrophic illnesses. As a tradeoff to secure this protection, we should set a national health and long term care expenditure cap.

Even in this time of tight budgets, Congress needs to take on this most difficult issue. Our own House Committee on Aging, as well as other committees, has held major hearings documenting two critical access deficiencies. First is the large number of Americans without any health insurance coverage -- 31-37 million people are uninsured.

The fundamental right of every American to access necessary health care can no longer be denied. We can no longer ignore the 31-37 million fellow Americans lacking insurance for either basic or catastrophic health care.

The second great deficiency is underinsurance, inadequate coverage for primary, acute, and long term care. Young families are more and more likely to be working for employers who provide no or only minimal coverage. Over 200 million Americans are without long term care protection -- be it public or private -- and are at major risk of financial disaster when hit by a catastrophic, chronic illness.

Americans find it unacceptable that those underinsured for long term care not only face the tragedy of severe long term care illness, but face a second tragedy -- a financial disaster striking both young and old. We can no longer ignore our nation's need for protection from and thus coverage for long term care costs.

A national health plan should build on the base of the Medicare program and ensure that all Americans be entitled to basic and catastrophic health insurance as well as comprehensive, flexible, managed and cost-capped long term care coverage.

This nation needs a comprehensive, national health plan, one that dismantles existing financial barriers to health care, slows the nation's escalating health care costs and improves health care quality. Also, the plan should take the unprecedented step of imposing a health and long term care cost cap at 12 percent of the Gross National Product.

Without such an approach, the Nation's health costs are projected to reach as high as 15 percent of the GNP by the year 2000. Yet, despite this enormous national investment, we would still not have resolved the crisis facing people with catastrophic illness and people without adequate health insurance protection. Setting a national health and long term care expenditure cap is a fair tradeoff to secure comprehensive protection for all Americans.

We should develop a carefully articulated system for providing long term care protection. Long term care expenditures should be capped at 1.1 percent of GNP and managed through a care management system which ensures that beneficiaries receive the care they need and that taxpayers will not face increases in costs beyond increases in their ability to pay. Further, long term care benefits should be flexible to best match beneficiary needs and promote beneficiary independence.

In the interests of making people aware of the cost of health care, cost sharing should be required on 20 percent of medical and skilled nursing home care and 25 percent of non-skilled long term care. This cost sharing should be capped by the catastrophic limits which are $600 per person per year for medical and skilled nursing care and $1,000 per person per year for non-skilled long term care.

Health care providers should be paid prospectively based on DRGs (Diagnostic Related Groupings) for hospitals and relative value scales for physician care. These fees should be developed in consultation with representatives of health care providers and indexed (to increases in per capita GNP) to our Nation's ability to pay.

We need a plan that brings about critically needed improvements without disrupting the essential professional and personal relationship between individual patients and their health care providers. Patient and health care provider "freedom of choice" should be preserved. Patients should be free to continue their relationship with their existing physician or hospital and free to choose among fee-for-service or capitation providers. Health care providers of all types should be included, including public providers and private profit and not-for-profit providers.

Through this plan, we should create a special partnership with the Nation's insurance industry which protects the financial viability of those companies while ensuring comprehensive coverage for every American. It should give the insurance companies a valuable role through contracts for a much larger volume of bill processing and review than under the current system, since the uninsured and recipients of long term care would be covered.

Finally, a national health plan should be totally self-financed through a funding package reflecting much of how we pay for care now. Funding should include:

* the savings generated by indexed prospective payment and capitation, beneficiary cost-sharing,
* an expanded cigarette tax,
* extension of the Medicare payroll tax to all incomes,
* a premium paid by the elderly (approximating the "Medicare premiums"),
* an employer tax based on compensation,
* State revenues covering 1/2 the cost of the poor, and
* a surcharge on corporate and individual income taxes sufficient for the solvency of the national health plan.

USHealth (H.R. 2980) has all of these provisions. I strongly believe that since a broad-based problem exists, only a broad-based solution like USHealth will provide the full health and long term care protection which Americans desperately require.

Fortunately, there is no shortage of options for dealing with this broad and tragic problem. It is also important to remember that all options get their funding from the same source, the pockets of the American people, though payment may be made through premiums, out-of-pocket, deferred wages (through employers), or taxes. The criteria for selecting a solution should be solely on what is the most efficient and effective way to use the American people's dollars to meet the American people's health and long term care needs.

Given the forces of change, the burdens of cost, and the inequities of access, the 101st Congress and the Bush Administration should make the commitment to protect the uninsured and underinsured. The risk to the uninsured and underinsured is great and grows daily. If not controlled soon, health costs will outdistance everyone's ability to pay for needed health care. We no longer can afford not to act.

USHealth (H.R. 2980) is my recommendation for building a truly American health care system, but is surely not the only answer. It is up to Congress and the Administration to make the final decision but I am confident that the USHealth Act as well as the plans advanced by Representative Waxman and Senator Kennedy and by our witnesses will be helpful in the enactment of a comprehensive solution to the comprehensive problems of access and affordability for the uninsured and underinsured, an incomplete quality assurance system, and rapidly rising health care costs.

USHealth An American Healthplan

EDWARD R. ROYBAL
Chairman, House Select Committee on Aging

THE "USHEALTH" PROGRAM ACT: AN AMERICAN HEALTHPLAN
(H.R. 2980)

A Bill to Contain Health Care Costs,
Maintain Quality and Ensure Access for All Americans

PURPOSE

Introduced by Representative Edward R. Roybal, this legislation, using the existing Medicare program as the foundation, is designed to control health care costs for all Americans whether they be individuals, employers, or the government; to maintain health care quality for all providers and patients, and to ensure financial access to health care and prevent financial disaster resulting from catastrophic illnesses.

BACKGROUND

From 1980 through 1987, health care costs rose at an average rate of 10.4 percent, or 3.3 percent faster than the Gross National Product. Health care costs continue to rise and are likely to reach a level of 13 percent of GNP by 1995 and nearly 15 percent by the year 2000. At the same time, the elderly are paying more and more of their limited incomes for health care even with the help of Medicare and Medicaid. Out-of-pockets costs are estimated to be as high as 18.1 percent of the elderly's income in 1988 -- substantially more than the 12.7 percent level of 1980 and the 15 percent level the Medicare and Medicaid programs began. On top of the elderly's growing financial burden and in spite of the enactment of Medicare and Medicaid, 37 million poor and near poor Americans still face major access problems due to lack of insurance. At the same time, over 200 million Americans -- about 85 percent of Americans -- are underinsured against catastrophic long term illness.

BILL OVERVIEW

The provisions of this bill establish the USHealth program in 1994 which is designed to contain costs while maintaining quality and ensuring access for all Americans. Health care cost increases will more closely match the increase in per capita Gross National Product -- a level which approximates the Nation's ability to pay. The provisions to ensure financial access for all Americans, including the poor, the unemployed, the uninsured, and the elderly are financed through the savings generated by the cost containment provisions, extension of the Medicare payroll tax to all incomes, beneficiary cost-sharing, an employer tax, an expanded cigarette tax, State revenues, a premium paid by the elderly approximating the "Medicare premium", and a surcharge on corporate and individual income taxes. The provisions to maintain quality include the active involvement of providers and consumers, the current Medicare quality assurance system (including Peer Review Organizations), qualified state quality assurance programs, a national Council on Quality Assurance, and the qualification of Health Maintenance Organizations.

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BILL SUMMARY

THE USHEALTH PROGRAM. The "USHealth Program Act," using the existing Medicare program as the foundation, is designed to control health and long term care costs for all Americans whether they be individuals, employers or the government; to maintain quality of care for all providers and patients; and to ensure financial access to health and long term care and prevent financial disaster resulting from catastrophic illness for all Americans.

Cost Containment. The cost containment program covers all services and patients. The cost containment provisions include paying all health care providers prospectively where payments are developed in consultation with providers. Future increases are limited to increases in the per capita GNP. States may set up alternative payment programs.

Cost sharing of 20% for health and skilled long term care and 25% for non-skilled long term care is required, but only up to the catastrophic limits described below. Cost sharing is optional for qualified HMOs. The poor (under 100% poverty) and those spending down into poverty are exempt from any cost sharing which prevents access to needed care.

The ceiling on total U.S. health costs is 12 percent of GNP under USHealth. Under that ceiling is a ceiling on long term care costs set at 1.1 percent of GNP indexed to changes in severity, ADL (Assistance with Daily Living) levels and cognitive impairment levels.

Access. Financial access is ensured by making every citizen and permanent resident eligible.

Benefits. Beneficiaries are protected from the cost of catastrophic illness. Their financial risk is limited to paying coinsurance as follows: a. 20 percent of health care and skilled nursing home and home health costs up to a maximum of $600 per person per year (indexed to per captia GNP), and b. 25 percent of long term care costs up to a maximum of $1,000 per person per year (indexed to per capita GNP).

The basic health and long term care benefits includes standard Medicare covered services as well as the following: inpatient hospital and inpatient psychiatric hospital services, medical and other health services, comprehensive outpatient rehabilitation facility services, health care services of a medical care access facility (Effective 1/1/90), extended care and nursing facility services, skilled home health services, hospice, alcohol and drug abuse rehabilitation, and outpatient mental health services (including community mental health centers and state-authorized services provided by a clinical psychologist, clinical social worker, or psychiatric nurse specialist). In addition to the services traditionally covered by Medicare, medical and other health services are expanded to include: nurse practitioner and clinical nurse specialist services (Effective 1/1/90), EPSDT (for those under age 21), family planning (individuals of child-bearing age), private duty nursing services, physical therapy, occupational therapy, speech-language therapy/pathology, audiology, and other medical or remedial care recognized under State law and specified by the USHealth program. Dental services, (including dentures), and eyeglasses are added before the year 2000 unless total USHealth expenditures would exceed 12 percent of GNP. As under Medicare, prescription drugs are covered but the annual deductible is reduced to $100. USHealth also covers physical checkups, health screening, immunizations, health risk reduction, and other preventive services.

More specifically, long term care (LTC) benefits are covered for chronically ill individuals (at least 2 age-appropriate ADL's or a similar level of cognitive impairment). Long term care benefits include: care management services, nursing care, services of a homemaker/home health aide, medical social services, medical supplies, physical/occupational/speech/respiratory/corrective therapy, patient and caregiver education/training/counseling, day health care, respite care (minimum of 120 hours/year if eligible), nursing facility services (as under the current Medicaid program), and limited transportation. Other long term care services, including personal care, may be covered if authorized by the care management agency and if total costs do not exceed expected cost.

Quality. The current Medicare quality assurance system, including Peer Review Organizations (PRO), is upgraded to place at least as much emphasis on quality assurance as on cost containment, cover all health care providers and consumers, cover all health services (hospital, physician, nursing home, home health), set up a national Council on Quality Assurance, add Consumer Boards to PROs, establish a patient bill of rights and create an ombudsman program. States have the option to develop their own qualified quality assurance system. Quality assurance is also addressed by federal HMO qualification.

Administration. The program is entitled "USHealth" and is managed by the USHealth Administration (thus replacing the ~~current~~ Health Care Financing Administration); the USHealth Program is independent and off-budget. Most bill processing and review will be provided through contracts with private insurance companies.

Financing. Health care cost increases will closely match increases in per capita GNP -- approximating the Nation's ability to pay. The provisions to ensure financial access for all Americans are financed as follows: the savings generated by indexed prospective payment and capitation, beneficiary cost-sharing, an expanded cigarette tax, extension of the Medicare payroll tax to all incomes, a premium paid by the elderly (approximating the "Medicare premiums"), an employer tax based on compensation, State revenues covering 1/2 the cost of the poor, and a surcharge on corporate and individual income taxes sufficient for the solvency of USHealth.

TRANSITION AND SYSTEM-BUILDING PROVISIONS. During the interim period between enactment of USHealth and 1994 (the first year of full implementation), the bill makes several changes which provide interim protection (e.g., extending Medicaid to cover the poor),and set up the transition to USHealth (e.g., conducting studies of prospective payment), and building up the health care system (e.g., developing rural and mental health care resources).

Medicaid Expansion. Over a three-year period, Medicaid protection is expanded to cover all persons with income at or below the Federal poverty level.

Private Insurance Deduction. Small businesses and self-employed individuals are allowed to deduct the total cost of their health insurance until USHealth is implemented.

Rural Health Care Development. Several provisions improve health care in rural areas by improving payment to rural health care providers, covering cost of Medical Care Access Facilities (MedCAF), authorizing a rural health services block grant, grants to develop medical practices, and ensuring that mental health services reach rural areas.

Direct Reimbursement of Nurse Specialists. As in the previous section for Medicare/USHealth, nurse practitioners and nurse specialists are covered by Medicaid.

Health Care Personnel Development. In order to better assure the availability of appropriate health care personnel, the bill expands the National Health Service Corps, establishes a Rural and Urban Health Assistance scholarship and loan repayment program, provides training funds, and expands the Area Health Education Centers.

Mental Health Care Development. Several provisions are designed to improve mental health care by funding research and demonstration projects, upgrading quality assurance and program effectiveness review and methodologies, requiring Medicaid coverage of mental health care, and changing the provision ensuring appropriate mental health care in nursing homes.

Alzheimer's Assistance Development. With respect to Alzheimer's, the bill creates and authorizes funding for State Alzheimer's programs. It also requires the Secretary to take several actions to assure adequate payment, quality of care, and access for Alzheimer's patients.

Community and Migrant Health Centers Expansion. As one way to reach underserved populations, the bill expands funding for community and migrant health centers by 10 percent.

THE "USHEALTH" PROGRAM ACT—BILL DESCRIPTION

In attempt to deal with the problems facing the American health care system, a series of changes are proposed. The provisions of this bill, if enacted, extensively modify the existing Medicare program in order to establish the USHealth program . This program contains health care costs for the federal government, States, employers, and consumers, improves financial access to needed services, helps maintain quality, and increases equity among health care providers and payers. The following reforms take full effect in 1994.

DIVISION A. USHEALTH PROGRAM.*

Title I. Eligibility and Enrollment.

Sec. 1101. Eligibility and enrollment. All U.S. citizens and permanent residents are eligible for the USHealth program. Enrollment in the USHealth Program is through the issuance of an account number either at time of birth or when issued a Social Security number.

Title II. Benefits and Providers.

Sec. 1201. Description of benefits. Sec. 1202. Changes in exclusions. Sec. 1203. Standards for certification of certain services. As of 1994, the basic health and long term care benefits package for all enrollees includes standard Medicare covered services as well as the following: inpatient hospital and inpatient psychiatric hospital services, medical and other health services, comprehensive outpatient rehabilitation facility services, health care services of a medical care access facility (Effective 1/1/90) (RUR), extended care and nursing facility services, skilled home health services, hospice, long term care for a chronically ill individual (LTC), alcohol and drug abuse rehabilitation, and outpatient mental health (Effective 1/1/90, including community mental health centers and state-authorized services provided by a clinical psychologist, clinical social worker, or psychiatric nurse specialist) (MH).

In addition to the services traditionally covered by Medicare, medical and other health services are expanded to include nurse practitioner and clinical nurse specialist services (Effective 1/1/90) (NRS), EPSDT (for those under age 21), family planning (individuals of child bearing age), private duty nursing services, physical therapy, occupational therapy, speech-language therapy/pathology, audiology, and other medical or remedial care recognized under State law and specified by the USHealth program. Dental services, (including dentures), and eyeglasses are added before the year 2000 unless total USHealth expenditures would exceed 12 percent of GNP. Mental health services are covered as under Medicare but the USHealth Board is to replace the current (Medicare) mental health limits on payments and covered services with an alternative system which better ensures access but contains costs. Medicare's outpatient mental health benefit limit is changed to 20 visits annually (which may be increased if necessary) and to not count mental health related medical management visits toward the limit (Effective 1/1/90) (MH). As under Medicare, prescription drugs are covered but the annual deductible is reduced to $100. USHealth also covers physical checkups, health screening, immunizations, health risk reduction, and other preventive services.

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* Certain provisions take effect for Medicare during the transition period prior to 1994 and are so noted with an earlier effective date.

More specifically, long term care benefits are covered for chronically ill individuals (at least 2 age-appropriate ADL's or a similar level of cognitive impairment). Long term care benefits include: care management services, nursing care, services of a homemaker/home health aide, medical social services, physical/occupational/speech/respiratory/corrective therapy, medical supplies, patient and caregiver education/training/counseling, day health care, respite care (minimum of 120 hours/year if eligible), nursing facility services (as under the current Medicaid program), and limited transportation. Other long term care services, including personal care, may be covered if authorized by the care management agency and if total costs do not exceed expected costs. Care management agencies are to be State agencies, except where not available, and are to carry out the assessment, develop a plan of care, and manage that plan of care. Full coverage is provided with the copayments made to the Trust Fund. The copayment is waived for low income and for spend-down individuals. As part of the long term care benefit package, incentives are to be developed to encourage families to keep a LTC family member in their home. Strong utilization review is instituted by PROs and intermediaries/carriers to control costs. (LTC)

(See Section [illegible]1.) Beneficiaries are protected from the cost of catastrophic illness but are required to pay coinsurance as follows: a. up to a maximum of $600 per person per year (indexed to per capita GNP) for health care and skilled nursing home and home health costs, and b. up to a maximum of $1,000 per person per year (indexed to per capita GNP) for non-skilled long term care costs.

Sec. 1204 (RUR) Development of Medical Care Access Facilities (MedCAF). Makes rural health care transition funds available for developing MedCAFs and expands the Rural Health Care Transition Fund to $45,000,000 by 1992. MedCAF (Medical Care Access Facility) is a facility which provides ambulatory, primary, emergency, urgent, and surgical care, provides basic inpatient care with up to 10 inpatient beds, and provides ancillary services including radiology and laboratory in frontier areas with populations between 1,000 and 5,000. The Secretary of the Department of Health and Human Services may waive the minimum and maximum populations qualifying for MedCAF designation when the geographic area is similar in character to MedCAF areas defined above. The maximum number of days allowed per hospital stay is 2 days (48 hours) with an exception process, through the Peer Review Organizations (PROs), allowing for additional days. Each MedCAF is required to have an approved quality assurance plan. (See detailed description in National Rural Health Care Act, H.R. 950).

Sec. 1205. (RUR) Rural Health Clinic demonstration program. Creates a rural health clinic demonstration program similar to the existing rural health clinic program but which allows use of a prospectively set fee schedule, covers preventive health services, and changes the minimum PA/NP time to 40 percent of clinic time.

Sec. 1206. (RUR) Rural and central city health care research and demonstrations. Provides for demonstration/waiver projects as to how to better cover rural and central city health care under Medicare and Medicaid.

Sec. 1207. Miscellaneous conforming and technical amendments. The bill treats Medical Care Access Facilities as a provider of services, adds long term care management agencies as a covered provider, and requires that long term home care services and acute home health services be coordinated so that receipt of long term home care not affect coverage for acute home health care. (RUR) (LTC).

Title III. Payments for Services.

Sec. 1301. Limiting rate of increase of all payment amounts. This bill incorporates a series of cost containment measures to keep total costs to no more than 12 percent of the Gross National Product and, in general, to keep long term care costs to no more than 1.1 percent of the Gross National Product. Greater incentives are provided for Health Maintenance Organizations. States are allowed and encouraged to implement state-wide cost containment programs as long as they perform as well as the federal program.

The USHealth Board makes adjustments in provider payments as necessary to maintain total program costs under 12 percent of GNP while ensuring that benefits are not reduced and out-of-pocket costs are not increased more than under current USHealth Program law. The "GNP" index is based on a 3-year moving average of increases in per capita GNP.

With respect to long term care, the USHealth Board makes other adjustments in long term care provider payments and the maximum monthly benefit for non-institutional care as necessary to maintain total long term care costs under 1.1 percent while ensuring that benefits are not reduced and out-of-pocket costs are not increased more than under the USHealth Program law as enacted initially. The ceiling of 1.1 percent is indexed to the changes in the U.S. population meeting the ADL and cognitive impairment standards and to changes in severity and resulting resource needs. At the State and local level, the care management agencies manage the authorized payment level for their clients. The maximum monthly benefit for noninstitutional care is limited to 95 percent of the expected cost if the chronically ill individual were in an extended care facility. (LTC).

Sec. 1302. Payments for inpatient hospital services. As of 1994, all inpatient hospital care is paid using Medicare's prospective payment system using the Diagnostic Related Groupings and adjusted for population differences (for example, based on a case severity or complexity index). Future hospital prospective payment rate increases are limited to increases in per capita Gross National Product as described in the cost containment section above. Capital is no longer allowed as a pass-through and is added to the DRG payment. The adjustment to a particular DRG payment reflects the amount of capital required for that DRG. The mean ratio of total capital outlays to total non-capital DRG payments is not to exceed the mean ratio for the most recent three years. Medical education is paid on the same basis as under current Medicare law.

Sec. 1303. Payments for other services. As of 1994, a fixed, prospective fee schedule is used to pay all providers in full for all non-hospital services (including medical, nursing home, home health, drugs, and laboratory). The fee schedule is developed by the USHealth Administration in consultation with the respective provider organizations (e.g., nurse practitioner and nurse specialty groups) and consumer groups. With respect to direct reimbursement of nursing services, a hot-line is set up to handle inquiries (NRS). In designing the fee schedule, adjustments should be made for differences in patient population, service type, and the "cost-of-doing-business", including resource inputs and input prices (e.g., malpractice insurance). For example, physician payments should address current inequities among geographic areas, physician specialties, and types of service. To the extent possible and appropriate, the fee schedule should reward higher quality providers. For comparison purposes, the mean weighted fee cannot exceed the mean fee for a similar service paid under the current Medicare system as amended by this Act. Except for adjustments to reflect service delivery changes, future fee increases are limited to no more than increases in per capita Gross National Product. Such increases may be adjusted to reflect changes in service delivery and billing practices.

Subject to guidelines established by the USHealth Board, all licensed individual health care practitioners may be reimbursed as health care providers.

Utilization review of all health and long term care services is conducted by the Peer Review Organizations and by insurance companies functioning as intermediaries/carriers. Intermediary/carrier review is strengthened to better control changes in billing practices, service volume, site of service delivery and service intensity.

Payments to all providers are to be adjusted as necessary to ensure reasonable availability of health care services in rural areas, central city areas and for other "special need" areas or populations.

States have the option to be exempt from the federal system and to implement their own alternative payment programs. In order to qualify for the exemption, the state program must meet or exceed the cost containment targets entailed in this bill and maintain access and quality equal to or exceeding the levels resulting from this bill. The alternative payment system must be mandatory for and equitably treat all types of providers covered under the State system.

For each State wishing to develop acceptable alternative payment programs, the federal government provides a three year development grant totaling between $1 million and $3 million. Those States with acceptable programs are eligible to have up to 50 percent of the savings (as compared to what would have paid under this amended law) added to reduce the state payment for the poor beginning in 1994. No additional state funds are needed to match this latter allocation.

Medical Care Access Facilities (MedCAF) are to be paid based on the type of service provided whether it be an inpatient service (DRG payment), emergency service (a combined professional and facility payment), or ambulatory care and other services (prospectively set fee based on relative value), (Effective 1/1/90) (RUR).

Sec. 1304. Direct payment for all services and use of intermediaries. As of 1994, the approved health care provider fee is full payment and is paid directly to the health care provider by USHealth. USHealth collects any coinsurance from the beneficiary.

In general, USHealth, as does Medicare, uses intermediaries and carriers to process health care provider claims and, to the maximum extent practicable, insurance companies are to be used as carriers.

Sec. 1305. Changes in HMO coverage and payment. HMOs are major providers of health care for beneficiaries. The USHealth Administration shall require participating HMOs (including HMOs, CMPs, and IPAs) to be qualified as specified under Title XIII of the Public Health Service Act beginning in 1994. HMOs must continue to be qualified on an annual basis. HMOs shall be penalized or removed from the program when they do not meet the HMO qualification standards. The Office of Health Maintenance Organization's cost for carrying out the ongoing qualification process is covered by the Trust Fund. Quality assurance review for HMOs is conducted by the Peer Review Organizations conducting review on non-HMO services.

As of 1994, the payment for HMOs is raised from 95 percent of the Average Area Per Capita rate (AAPC) to 100 percent of AAPC. The AAPC is adjusted by age, sex, enrollee type, and appropriate health status factors.

Publications are provided which give side-by-side comparisons of HMOs in each area of the country. The use of HMOs is promoted, including the provision of a comparison of HMOs with the non-HMO providers in terms of quality assurance, covered services, and out-of-pocket costs to the elderly and disabled.

Title IV. Financing Program.

In order to finance the USHealth program and to provide an orderly transition from the current system of financing health care, USHealth is financed through the revenue sources listed below. Much of the long term cost of expanding access and reducing costs for all beneficiaries comes from reducing health care cost inflation for all payers and for all health care providers. Health care costs savings are expanded by holding cost increases down to per capita growth in GNP and by controlling utilization. Beneficiary cost-sharing applies to all services but is limited by the catastrophic provisions.

Sec. 1401. Limited coinsurance and copayments with protection against catastrophic expenses. Beneficiaries are protected from the cost of catastrophic illness but do contribute to the financing of USHealth by paying coinsurance as follows:

a. 20 percent of health care and skilled nursing home and home health costs up to a maximum of $600 per person per year (indexed to per capita GNP), and
b. 25 percent of long term care costs up to a maximum of $1,000 per person per year (indexed to per capita GNP).

The above coinsurance provision is waived for individuals in families with incomes under the poverty level and for individuals whose health care costs require the family to spend down below the poverty level. However, a nominal copayment may be charged to the poor as long as it does not prevent access to needed health care.

Coinsurance payments are collected by USHealth for the beneficiary and made directly to the Trust Fund. The failure to make payments does not result in a loss of the entitlement but USHealth will pursue payment where appropriate.

Sec. 1402. Extension of hospital insurance tax to all wages. The "Medicare payroll tax" is expanded to cover all income levels. (Effective 1/1/90).

Sec. 1403. Elimination of Part B Medicare premiums for disabled beneficiaries and phase-out of Part B Medicare premiums for elderly beneficiaries. The Medicare Part B premium is eliminated for disabled beneficiaries. The Part B premiums (regular and catastrophic) for elderly beneficiaries is phased out beginning in the year 2000 by reducing it by 20 percent until it is eliminated in the year 2004. The premium is waived for elderly beneficiaries who are under the federal poverty level.

Sec. 1404. Changes in Medicare supplemental premium. Beginning with the year 1994, the Medicare supplemental income-related premium (Medicare Catastrophic Coverage Act) rate is frozen and is subsequently reduced by $4 each year until it is phased out completely in the year 2005. The limit on the premium is indexed to the growth in per capita GNP until the premium is phased out.

Sec. 1405. Excise tax on wages and self-employment income. Employers pay a tax based on a percentage of employee compensation. The basis for setting that percentage is the aggregate amount which employers are paying under the current system for employee and retiree health benefits in 1988.

Sec. 1406. Increase in federal excise tax on cigarettes. The cigarette excise tax is raised by 16¢ and indexed to per capita GNP. (Effective 1/1/90).

Sec. 1407. State contributions. States provide contributed revenues equal on average to one-half of the cost of the poor (i.e., everyone under the Federal poverty level). Payment formula is as follows: (total national cost of poor) X 1/2 X (State population/US population) X (State per capita income/National per capita income).

Sec. 1408. Tax surcharge on all taxpayers. An earmarked surcharge on all corporate and personal income taxes is made which equals the amount necessary to maintain the solvency of the USHealth Trust Fund. The financing formula is as follows: total USHealth expenditures minus cost sharing minus cost savings minus State share minus cigarette add-on minus the "Medicare payroll tax" minus the employer tax minus other revenue additions = Net revenue required from an X% surcharge on Federal corporate and individual income tax.)

Sec. 1409. USHealth Program Trust Fund. Revenues are placed in the USHealth Trust Fund which is off-budget. The law requires USHealth to be self-funding and prohibits the transfer of funds from general revenues into USHealth and from USHealth into the general fund of the Treasury. Within 6 years, the Trust Fund should have an appropriate reserve for contingencies.

Sec. 1410. Repeal of exclusion from income of employer health insurance contributions. Employers would no longer be able to exclude employer health insurance contributions from their taxable income.

Title V. Quality Assurance.

The current Medicare quality assurance (QA) system, which includes Peer Review Organizations and nursing home quality assurance is upgraded to cover all medical services (inpatient and outpatient) for all patients and all providers and to place at least as much emphasis on quality assurance as on cost containment. Most provisions are to be phased in as of January 1, 1993. A State has the option to obtain a waiver from this requirement if it establishes its own plan of quality assurance and as long as it provides at least the same level of protection as the amended federal plan.

Sec. 1501. National Council on Quality Assurance. This bill establishes a national Council on Quality Assurance (CQA) to provide oversight on the operations of the quality assurance system and make recommendations to DHHS and, subsequently, the USHealth Administration and to the Congress for its improvement. Its oversight function includes the review of the administration of quality assurance, the overall performance of the PROs and waivered state plans, reports of the Consumer Boards, quality assurance studies and methodologies developed by DHHS, the USHealth Administration and others, the data needs of the PROs, and input from interested parties.

DHHS and, subsequently, the USHealth Administration are required to provide such information as is needed by CQA to carry out its responsibilities. Based upon these reviews, the Council is to make recommendations annually for improving quality assurance to DHHS and, subsequently, the USHealth Administration and to the Congress. DHHS and, subsequently the USHealth Administration are required to take into account CQA input in its administration of the PRO program.

The Congressional Office of Technology Assessment (OTA) will provide for the appointment of the fifteen member Council consisting of equal numbers of health care providers, health care consumers, and experts in quality assurance. Subject to the review by OTA, the Council may employ staff as necessary to carry out these functions.

Sec. 1502. Emphasis by peer review organizations on quality assurance. This bill requires DHHS and, subsequently, the USHealth Administration to award, administer, and evaluate its PRO contracts under the stipulation that at least one-half of the PROs' level of effort is for the purpose of quality assurance as of January 1, 1990.

This bill requires that health and home care agencies have plan of care policies which identify services to be provided, provide a means for identifying additional client needs, and include coordination mechanisms with other service agencies.

Sec. 1503. Extension of quality assurance to all services (Effective 1/1/90). This bill requires the DHHS and, subsequently, the USHealth Administration and its contract PROs to conduct quality assurance for all patients. This bill requires the DHHS and, subsequently, the USHealth Administration and its contract PROs to conduct quality assurance activities on all medical providers including hospitals, physician offices, nursing homes, home health agencies, hospices, nurse practitioner and nurse specialty services (NRS), and HMOs and other alternative delivery systems. The level of PRO effort expended on each type of provider reflects the proportion of national health care expenditures for this type of provider and the need for review. Similarly, membership on the PRO governing body and its composition reflect the range of health care providers reviewed by the PRO.

Sec. 1504. Consumer boards. This bill requires each PRO to have a Consumer Board (CB) which conducts ongoing oversight of the PROs, provides input into the award and evaluation of PRO contracts, and can receive input from Medicare beneficiaries and other interested parties. The CB and the PRO are responsible for educating consumers on quality assurance and on the availability of assistance from the PRO and other agencies. The PRO makes available to the CB such information and staff as are necessary to carry out the CB function. This does not include information where either the individual health care provider or consumer can be identified.

The CB is required to prepare an annual report on the PRO's performance and submit that report to the respective Governor(s), to the national Council on Quality Assurance, and to DHHS and, subsequently, the USHealth Administration. CB input is to be utilized in decisions to award PRO contracts.

The CB consists of 5-7 volunteer members appointed by the respective Governor of the State covered by the PRO and representing organizations of the elderly, the disabled, the poor and other consumers. In addition to the CB, each PRO has at least one health consumer, who is not a health care provider, on its Board of Directors.

Sec. 1505. Quality assurance hot-line. This bill requires PROs to have a 7-day-a-week hot-line for receiving questions and complaints from health care providers, consumers, and interested parties concerning health care quality problems. PROs are required to assist in the resolution of any legitimate quality related problems. The USHealth Administration, in coordination with each PRO, shall provide beneficiaries with the hot-line number for their PRO in a way that can be easily attached to their USHealth cards. The PRO hot-line is coordinated with the hot-lines operated by the Ombudsman program and any State quality assurance programs.

Sec. 1506. Funding of increased activities. As compared to current law and adjusted for inflation, the funding level for the PRO program is increased by 50 percent in FY 1994 (first year of implementation), by 65 percent in FY 1995, and by 75 percent in FY 1996 and in subsequent years. The funding for the CQA and the PROs program will be made from the Trust Fund. For those States with their own federally qualified quality assurance plans, the USHealth Administration is authorized to make available funds up to the amount that would have gone to the respective PRO as authorized above.

Sec. 1507. (LTC), Assuring quality of care management and home care services. This bill sets home care and care management quality assurance standards and required compliance as a condition of participation under USHealth. Home health agencies are required to follow the consumer bill of rights, set up grievance procedures, assure adequate training of home care personnel, properly supervise home care providers, develop patient plans of care, and arrange for discharge/transfer. The Board may provide for a temporary waiver if access would be limited.

The requirements for long term care management agencies are somewhat similar to those for home care agencies.

The USHealth Board will arrange for periodic survey of both types of agencies. States are encouraged to develop licensing policies for home health agencies.

Training grants for home health agencies, home care providers, and long term care management agencies are authorized up to a total of $50,000,000 for FYs 1993 and 1994.

Sec. 1508. Hospital discharge planning process. (Effective 1/1/92). This bill sets guidelines for discharge planning to protect against inappropriate discharges and to ensure a smooth and timely transition to post-hospital care. It also requires that hospitals have in place a discharge planning process that begins as close to the time of hospital admission as appropriate and that alerts nursing home and home health providers of a patient's anticipated need for post-hospital care at the earliest possible time.

Sec. 1509. (MH) Assuring pre-paid organizations provide quality, accessible mental health services. (Effective 1/1/91) Prepaid health plans under Medicare are required to have quality mental health services accessible to their Medicare enrollees.

Sec. 1510. Consumers' bill of rights. This bill establishes a federal bill of rights for health care consumers under USHealth.

Sec. 1511. Health and long term care ombudsman. This bill establishes a Health and Long Term Care Ombudsman Program to investigate and resolve health and long term care provider service complaints and to provide information on health and long term care provider services. The Ombudsman hot-line is coordinated with the hot-lines operated by the PRO and any State quality assurance programs. Funding for the Health and Long Term Care Ombudsman is authorized at $55,000,000 for 1994. In each subsequent year, the amount will be the previous year's authorization increased to reflect increases in per capita GNP.

Sec. 1512. Studies and reports. The USHealth Administration shall prepare an annual report which assesses the performance of the quality assurance system and addresses the recommendations of the CQA and the concerns and recommendations of the CBs. DHHS and, subsequently, the USHealth Administration shall analyze the impact which the federal cost containment system, limitations on health care provider payments, and Health Maintenance Organizations have had on health care quality, access and beneficiary cost and submit an annual report to Congress. The USHealth Administration shall conduct studies on and develop improved methodologies for quality assessment and assurance for health care services including hospital, physician, nursing home, home health services, and hospice services. The USHealth Administration shall submit an annual report to Congress on the progress toward developing such methodologies.

Title VI. Administration and Miscellaneous.

Sec. 1601. Establishment of USHealth Program Administration as a separate, independent agency. Responsibilities of the agency. Overall administration is by the federal government's USHealth Administration (currently, the Health Care Financing Administration (HCFA)) which is both off-budget and operates as an independent agency.

USHealth is overseen by the USHealth Board. The Health Board has responsibilities for and control over the program subject to the the law or subsequent changes in the law, establishing the USHealth program. The Health Board members are appointed by the President with the consent of the Senate. The Administrator of the USHealth Administration reports to the USHealth Health Board. Within the USHealth Administration, an Ombudsman office is established to represent beneficiary interests and help resolve beneficiary problems.

USHealth replaces the current Medicare and Medicaid programs and is built upon these two programs.

Sec. 1602. Transfers to the new USHealth Administration. All functions currently carried out by the Health Care Financing Administration (HCFA) are transferred to the USHealth Administration and HCFA is abolished.

Sec. 1603. Transitional rules.

Sec. 1604. (LTC) Demonstration Projects. The Secretary is required to carry out the following demonstration projects: demonstrations of different models for care management and demonstrations of how best to cover day health care under long term care.

Sec. 1605. Effective dates of title.

Sec. 1606 Conforming amendments to the Social Security Act.

Sec. 1607. Rules of construction.

Title VII. Miscellaneous Provisions.

Sec. 1701. Repeal of Medicaid program. The Medicaid program is repealed as of January 1, 1994.

Sec. 1702. General effective date and savings provision for Medicare and Medicaid. In general, USHealth and all its provisions (unless otherwise noted) take effect as of January 1, 1994.

Sec. 1703. Additional conforming and technical amendments.

DIVISION B. TRANSITION AND SYSTEM-BUILDING PROVISIONS.

Title I. Medicaid Expansion to Cover Poor. (Sec. 2101) (RUR)

In order to ensure improved and uniform access by lower income rural and urban residents, Medicaid eligibility for "categorical" benefits is changed to cover all people whose incomes are at or below 100 percent of the Federal poverty level and whose resources do not exceed twice the SSI level. As of January 1, 1990, all children (18 or under) whose incomes are at or under the Federal poverty level are covered by Medicaid. As of January 1, 1991, all other people whose incomes are at or under 90 percent of the Federal poverty level are covered. As of January 1, 1992, all persons whose incomes are at or under 100 percent of the Federal poverty level are covered by Medicaid.

Title II. Private Health Insurance Deduction. (Sec. 2201) (RUR)

Health insurance for self-employed individuals, small businesses and farms, is fully deductible under the same rules as for larger businesses for the years 1991 through 1993. (See earlier financing section for repeal of deduction as of end of 1993).

Title III. Rural Health Care Development.

Sec. 2301. (RUR) Special Medicaid payment rules for payment for rural medical practice, rural nursing facilities, and rural home health agencies. (Effective 1/1/91-12/31/94). In setting payment rates for rural medical practices, the rates are to utilize a cost-of-doing-business adjustment, incorporating differences in physician cost, nurse cost, utilities, equipment and supplies, and capital costs, in each payment category. A provision is made for a separate adjustment on a per payment basis for providing the capability (24-hour on-call coverage and "down-time" in low volume areas). In general, the Secretary of the Department of Health and Human Services, in consultation with primary care providers and consumers, is to design an appropriate system and to reduce the differential between urban and rural physician, physician assistant, nurse practitioner, nurse, and other health personnel cost factors so as to provide a reasonable incentive to practice in rural areas.

Additional changes in payments for rural medical practices include: a) paying at the same rate for the same type of urgent/emergency visits provided at either the hospital emergency room or a physician's office while allowing hospitals to bill for the overhead costs they can currently, and b) paying for an after-office-hours phone call for the purpose of triaging patients.

Rural nursing homes are given the option to be paid on a prospectively set "daily rate" schedule, designed by the Secretary of the Department of Health and Human Services in consultation with nursing homes and consumers. The schedule varies by type of patient and is tied to a cost-of-doing-business index (e.g., index should take into account higher overhead costs and/or stand-by capability).

Home health agencies are given the option to be paid on a prospectively set "per type of visit" schedule, designed by the Secretary of the Department of Health and Human Services in consultation with home health agencies and consumers. The schedule is tied to a cost-of-doing-business index (e.g., index should take into account higher overhead costs and/or stand-by capability).

Sec. 2302. (RUR) Medicaid coverage of services of medical care access facilities. (Effective 1/1/91-12/31/94) Medical Care Access Facilities (MedCAF) can be covered under Medicaid as under the Medicare/USHealth program. (See above.)

Sec. 2303. (RUR) Placement of office of rural health care in the office of the Secretary of Health and Human Services. As of enactment, the Office of Rural Health Care is to be located in the Office of the Secretary of the Department of Health and Human Services.

Sec. 2304. (RUR) Rural health service block grant.
State Rural Health Planning Grants. Health planning grants are to be made available to States in order to develop rural health access plans. State plans are to address how federal and state program funding, (including preventive, community health services, and EMS block grants, immunization funding, occupational safety and health programs, sexually transmitted diseases funding, and the maternal and child health block grant), could better address access problems in rural areas. The formula for distributing available funds among the States is tied to ratio of non-MSA population in a State to non-MSA population in the U.S. population. The minimum for a grant is $100,000. Authorized funding is $20 million for 1990, $21 million for 1991, and $22 million for 1992.

Emergency Medical Services. A seperate rural Emergency Medical Services (EMS) block grant is established. In order to receive funding under the rural EMS block grant, the State is required to have a state rural health plan which is acceptable to the Secretary of the Department of Health and Human Services. Funding is available for start-up costs for transportation and communications and ongoing costs for uncompensated trauma care and transportation. The formula for distributing available funds among the States is tied to ratio of non-MSA population in the U.S. population. The minimum for a grant is $100,000. Authorized funding is $150 million for 1990, $156 million for 1991, and $160 million for 1992.

Sec. 2305. (RUR) Medical practice development grants. Medical Practice Development Grants for solo and group practices, rural health clinics, and MedCAFs are to be made available to increase the number of health care providers serving underserved rural areas. (MedCAF Development Grants are to be included as described earlier. See above.)

Medical Practice Development Grants - Solo and Small Group Practices. Rural Medical Practice Development Grants are to be available for solo and small group practices. These grants (for training, supplies and equipment) are for practices which increase access to primary care and provide 24-hour urgent care. They require documentation of personnel training and/or proficiency. Grantees are required to accept Medicare and Medicaid patients. Start-up grants are available up to $20,000 and may be coupled with annual grants of $1,000. (Authorizes $6 million for 1990, $7 million for 1991; $ 5 million for 1992).

Medical Practice Development Grants - Rural Health Clinics. Rural Medical Practice Development Grants are to be available for rural health clinics as well. Grants for training, supplies, and equipment are available for those which will increase access to primary care and will provide 24-hour urgent care. Clinics are required to accept both Medicare and Medicaid patients. They are also required to provide documentation of personnel training and/or proficiency. Authorized funding is $20 million for 1990, $30 million for 1991, and $30 million for 1992. Start-up grants are available as follows:

Frontier areas -- These areas are eligible for start-up grants of up to $120,000 for clinic operations (maximum of 25% of grant), training, supplies, equipment and facility. A 25% match is required from the local area or the State. Also, clinics are eligible for annual non-matching grants of $1000. Eligible sites are required to be in a frontier service area consisting of less than 6 persons per square mile and at a distance of more than one-half hour travel time from a city of 2,500.

Rural counties (non-frontier) -- These areas are eligible for start-up grants of up to $120,000 for clinic operations (maximum of 25% of grant), training, supplies, equipment, and facility. A 75% match is required from the local area or the State. Also, clinics are eligible for annual non-matching grants of $1000. Eligible sites are required to be in a small rural county, less than 20,000.

Medically Underserved Areas (MUA) -- These areas are eligible for start-up grants of up to $120,000 for clinic operations (maximum of 25% of grant), training, supplies, equipment, and facility. A 25% match is required from the local area or the State. Also, these clinics are eligible for annual non-matching grants of $1000.

Sec. 2306. (RUR) Rural health care research projects. The National Center for Health Services Research is required to commit a minimum of 5 percent of new grant projects (for fiscal years 1990, 1991, and 1992), for research relevant to improving rural delivery systems. In addition, the National Center for Health Statistics is to conduct a study on how to improve the availability of data for determining medically underserved rural areas and for monitoring changes in the health status of rural residents.

Sec. 2307. (RUR) Alcohol, drug abuse, and mental health block grant. (Effective January 1, 1990). States receiving alcohol, drug abuse and mental health block grants from the Alcohol, Drug Abuse and Mental Health Administration are required to document the mental health needs in rural areas and document State's level of effort with respect to providing mental health services in rural areas.

Sec. 2308. (RUR) National Institute of Mental Health. Funding is provided for research on rural mental health care delivery systems through the National Institute on Mental Health. Authorized funding is $5 million for 1990, $5 million for 1991, and $5 million for 1992.

Title IV. Direct Reimbursement of Nurse Specialists. (Sec. 2401) (NRS)

As with the previous Medicare/USHealth provisions, the bill provides direct Medicaid reimbursement for nurse practitioners, clincal nurse specialists, certified nurse midwives, and certified registered nurse anesthetists beginning January 1, 1991. Servicing are defined as those services covered as physician services and within the scope of state nursing practice laws. These services could include services provided in nursing homes, hospitals, patient homes, and ambulatory care settings.

Title V. Health Care Personnel Development.

Sec. 2501. (NRS) National Health Service Corps scholarship program and loan repayment program. For the National Health Service Corps, the authorized funding for scholarships and loan repayments is $15 million for 1990, $16 million for 1991, and $17 million for 1992.

Sec. 2502. (NRS) Rural and urban health assistance scholarships and loan repayments. In addition to the current National Health Service Corps, Rural and Urban Health Assistance Scholarships and loan repayments are established at an increased level from the current NHSC. A minimum of forty percent of placements (by type of student) are targeted for underserved rural areas. The percentage of total placements which are made at federal prisons is limited to one percent. Eligible sites for placements include those sites eligible under the current NHSC program, MedCAPs, rural health clinics (current and optional demonstration program), and private practices in priority underserved rural or urban areas. Scholarship students are required to serve one year in an eligible site for every year in which a full scholarship is received. Loan repayments are treated the same way as in current loan repayment programs.

Eligible students include primary care physicians (with the primary emphasis being on those in family practice), nurses, nurse practitioners, physician assistants, psychologists, clinical social workers, pharmacists, dentists, and other allied health professionals.

For the National Health Service Corps, the authorized funding for scholarships and loan repayments is $15 million for 1990, $16 million for 1991, and $17 million for 1992. (This is the same as or similar to the Rural Health Coalition Proposal.) For the Urban and Rural Health Assistance Scholarships and loan repayments the authorized funding is $15 million for 1990, $20 million for 1991, and $22 million for 1992.

Sec. 2503. (NRS) Health care personnel training programs.
Primary Care Personnel. Effective January 1, 1991, training programs (for primary care physicians, nurses, nurse practitioners, physician assistants, psychologists, clinical social workers, pharmacists, dentists, and other allied health professionals) are funded by the federal government and would be required to provide assurances that training takes into account special practice conditions of rural areas and target efforts toward students who are more likely to locate in underserved rural areas. To encourage the training of health care professional who are more likely to serve underserved rural areas, development grants are provided to health training programs (for primary care physicians, nurses, nurse practitioners, physician assistants, psychologists, clinical social workers, pharmacists, dentists, and other allied health professionals) to develop and support training programs which can best place providers in underserved rural areas. Authorized funding is $10 million for 1990, $12 million for 1991, and $13 million for 1992.

Multi-competent Technicians. New training program funding is established to train multi-competent technicians to serve in underserved rural areas. Demonstration program grants may be made to hospitals, colleges, and technical schools to develop model training programs for multi-competent technicians. Multi-competent technicians are technicians skilled by education/experience to perform limited routine laboratory procedures, including, limited radiography (chests, extremities, and abdomen) as well as cross trained as EMT I and/or II per DOT guidelines. Authorized funding is $1 million for 1990, $2 million for 1991, and $2 million for 1992.

Sec. 2504. (NRS) Area health education centers. Funding for Area Health Education Centers is increased and is to be targeted toward those health professions which are in short supply. The requirement for the number of residencies is reduced to two. Medical schools are required to provide at least a half-time tenured faculty member to serve as the director. Authorized funding is $20 million for 1990, $21 million for 1991, and $22 million for 1992.

Sec. 2505. (NRS) Continuing education for nurses in rural areas. Effective upon enactment, continuing education of nursing personnel is increased through a program to bring continuing education (e.g., via satellite transmission) to rural areas. This program is designed to offer continuing education to nurses so they will be able to maintain and upgrade their skills and to counter the sense of professional and educational isolation.

Title VI. Mental Health Care Development.

Sec. 2601. (MH) Research and demonstration projects. Biomedical, behavioral, and social research on prevention, treatment, and service delivery for mentally impaired elderly is increased. The Department of Health and Human Services is required to develop a plan of prevention, treatment, and service delivery research related to elderly mental health and psychosocial well-being and to implement it through the National Institute on Aging, the National Institute of Mental Health, and the Administration on Aging.

- Adds $8 million in FY 1990, $16 million in FY 1991, and $24 million in FY 1992 to NIMH research programs on elderly mental health. At least 10% of these funds are to be used for service delivery research.
- Adds $4 million in FY 1990, $8 million in FY 1991, and $12 million in FY 1992 to NIA's research programs on elderly mental health and psychosocial well-being. At least 10% of these funds are to be used for service delivery research.
- Adds $2 million in FY 1990, $4 million in FY 1991, and $6 million in FY 1992 to AoA's research and demonstration programs on elderly mental health.

Sec. 2602. (MH) Quality assurance and program effectiveness study. The Secretary of the Department of Health and Human Services is required to contract with the Institute of Medicine for a study of quality assurance and program effectiveness with respect to mental health services. The study is to determine methods for measuring and assuring the quality and program effectiveness of mental health services and alcohol and drug abuse treatment services as provided in various settings, including psychiatric hospitals, inpatient psychiatric units in general hospitals, nursing homes, community mental health centers, and other ambulatory care settings. The study is to develop recommendations to providers, program administrators, and payers, including Medicare and Medicaid. Funding is set at $500,000 for fiscal year 1990. The study is to be completed and a report submitted to Congress within 18 months of the signing of the contract.

Sec. 2603. (MH) Additional studies on mental health services. The Institute of Medicine is requested to conduct a study comparing mental health services, benefits, access, and quality under Medicare and non-Medicare prepaid health plans, and in settings other than prepaid plans.

Mental Health Facilities. The Secretary of Health and Human Services is directed to conduct a study examining mechanisms for ensuring quality of and access to mental health services delivered by state and local mental health facilities and by independent providers of mental health services.

Minority Access to Community Mental Health Centers. The Secretary of Health and Human Services is directed to conduct a study examining the representations of racial and ethnic minorities among persons receiving Community Mental Health Center Services, including current level of utilization and the level of unmet present and future need. In addition, the Secretary is to conduct demonstration projects as to how to increase minority utilization to appropriate levels.

Mental Health Manpower. The Secretary of Health and Human Services is directed to conduct a study examining (a) the adequacy of manpower for meeting present and future mental health needs of the elderly, and (b) the optimal utilization of the various types of mental health professionals for meeting those present and future elderly mental health needs. Also, the Secretary of Health and Human Services is to conduct a study examining the adequacy of (a) manpower for meeting present and future mental health needs of ethnic and minority group elderly, and (b) opportunities for training ethnic and minority group mental health professionals.

Sec. 2604. Effective date. The above mental health provisions take effect on October 1, 1989 or upon enactment.

Sec. 2611. (MH) Requiring provision of outpatient mental health under Medicaid (Effective 1/1/90-12/31/94). Medicaid programs are required to include community based mental health services for eligible recipients, including those in their homes or in a nursing home, on the same basis as physician services.

Sec. 2612. (MH) Classification of institution for mental diseases under Medicaid. (Effective 1/1/90-12/31/94). The definition of Institution for Mental Disease under Medicaid is clarified as follows. It specifies that a facility may be classified as an Institution for Mental Disease (IMD) under Medicaid only under the following conditions: (1) the facility is under the jurisdiction of the State's mental health authority, (2) the facility advertises itself as primarily specializing in the treatment of individuals with mental disease, or (3) based upon current diagnosis, less than 50 percent of all patients in the facility have a physical condition independently sufficient to require nursing home care. The delivery of mental health services or psychopharmacological drugs to patients with physical conditions independently sufficient to require nursing home care shall not be considered an indication that a facility is an Institution for Mental Disease (IMD) under Medicaid. Further, a facility staffed with specialized psychiatric or psychological trained persons shall not be considered an indication that it is an Institution for Mental Disease (IMD) under Medicaid.

Sec. 2613. (MH) Conditions of participation for nursing facilities under Medicare and Medicaid. Effective with OBRA '87, access to mental health services for all nursing home patients is required as a condition of participation under Medicare and Medicaid.

Sec. 2614. (MH) Additional conditions of participation. (Effective 1/1/91). The Department of Health and Human Services is required to establish conditions of participation as follows:

- All mental health providers under Medicare and Medicaid shall (a) comply with the Consumer Bill of Rights (see Bill of Rights below), (b) provide the client with written grievance procedures appropriate for all services, and (c) give in writing the services to be provided. Note: In this Act, "mental health providers" means a psychiatrist, psychologist, clinical social worker, psychiatric nurse specialist, psychiatric hospital, hospital programs (under section 1905 (i)), and an institution for mental diseases.
- All mental health providers under Medicare and Medicaid shall have (a) the capability to identify clients who may be in need of mental health services, (b) the capability to provide such services or to make appropriate referrals for such services, and (c) the means to coordinate with other agencies, programs, and services providing mental health services or other services to the client.
- All mental health providers under Medicare and Medicaid shall (a) include in their client assessments an assessment of mental health needs at a level sufficient to identify clients for whom a comprehensive mental health assessment, conducted by a mental health professional, is indicated, (b) provide or arrange for such comprehensive mental health assessment when indicated, and (c) when appropriate, include mental health services in plans of care and discharge planning.
- All mental health providers under Medicare and Medicaid shall have (a) client care processes which include a plan of care which states reasonable goals and objectives, services to be provided to meet those objectives, and outcome measures for each client served, (b) a method for periodic review of client needs and the plan of care, and (c) a statement of criteria for discharge and/or transfer to another agency, program, or service.
- All health maintenance organizations or competitive medical plans providing services under Medicare and Medicaid shall provide, according to regulations determined by the Secretary of Health and Human Services, an appropriate package of mental health benefits and an appropriate mechanism for ensuring quality of and access to services provided under those benefits.
- All hospitals and nursing homes providing services to chronically mentally ill individuals under Medicare and Medicaid shall have a discharge plan for all such individuals which assures that they will have a plan for mental health care and for coordination of services established prior to discharge.

Sec. 2615. (MH) Peer review of mental health services. For both Medicare and Medicaid, future contracts (after enactment) for PRO review shall incorporate review of all new and current services provided under those programs as a result of this Act.

Sec. 2616. (MH) Review of levels of payment for mental health services. (Effective 1/1/90). Secretary is required to review adequacy of mental health payments for nursing home residents.

Title VII. Alzheimer's Assistance Development.

Sec. 2701. (ALZ) Grants to states for Alzheimer's Disease programs. A joint federal/state effort is established to develop services and policies to assist victims of AD and their families. All 50 States and territories may receive grants to create State Alzheimer's Programs.

- Develops diagnostic, treatment, care management, legal counseling, and educational services for care providers, victims, and their families. Makes available respite care services (including, but not limited to, home health, day care, companion, short term stay in health facilities), for the AD patient. Between 25% and 50% of the grant is to be used for this purpose. Disseminates information to victims, their families, health care providers, and organizations established for patients with AD, and to the general public on services available to AD victims as well as on rights of and sources of assistance for AD victims and their families.
- Review state policies on the financing and reimbursement of the costs of health care for patients with AD and identifies other policy changes that would improve the care of patients with AD.
- Makes initial grants available for 3 years with funding at a minimum of $250,000 per year and subject to an annual evaluation by the Department of Health and Human Services. States are required to provide matching funds at a 50-50 rate. Total program funding is set at $50 million for 1990, $100 million for 1991, and $125 million for 1992.

Sec. 2711. (ALZ) Assuring adequate funding for treatment of individuals with Alzheimer's Disease. (Effective 12 months after enactment). The Health Care Financing Administration (HCFA) is directed to modify the Medicare and Medicaid programs to review and, as needed, modify reimbursement for home health services, extended care services, and inpatient hospital services to reflect more accurately the cost of caring for advanced stages of AD.

Sec. 2712. (ALZ) Upgrading quality of care reviews for heavy care patients. The Health Care Financing Administration (HCFA) is directed by January 1, 1990 to modify the Medicare and Medicaid programs to upgrade quality of care and utilization reviews for heavy care patients such as AD patients.

Sec. 2713. (ALZ) Assuring access to needed services. The Health Care Financing Administration (HCFA) is directed to propose modifications (within 12 months after enactment) in the Medicare and Medicaid programs to ensure that access to nursing home and home health care for AD victims is not limited by the practices of nursing home and home health agencies.

Title VIII. Community and Migrant Health Centers Expansion. (Sec. 2801) (RUR)

Community health center and migrant health center funding authorization is increased by 10 percent each. Authorized funding for community health centers is $517 million for 1990 and such sums as are necessary for subsequent years. Authorized funding for migrant health centers is $55.5 million for 1990 and such sums as are necessary for subsequent years.

As noted in the text, several provisions in the "USHealth" Program Act are drawn from other legislation introduced by Representative Edward R. Roybal, including the Mental Health and Aging Act (H.R. 111), the National Rural Health Care Act (H.R. 950), the Nursing Shortage and Nurse Reimbursement Incentives Act (H.R. 1140), the Comprehensive Alzheimer's Assistance, Research, Education Act (H.R. 1490) and an expanded version of "Pepper-Roybal" Long Term Home Care Act (H.R. 2263). In the bill description, these provisions are indicated by the following initials: "MH" -- H.R. 111, "RUR" -- H.R. 950, "NRS" -- H.R. 1140, "ALZ" -- H.R. 1490, and "LTC" -- a comprehensive long term care package which includes most of H.R. 2263.

For more information on the "USHealth" Program Act, contact Gary Christopherson, Yvonne Santa Anna, or Julie Utroska at the House Select Committee on Aging (202-226-3375), Room 712, House Annex 1, Washington, D.C. 20515.

USHealth *An American Healthplan*

EDWARD R. ROYBAL
Chairman, House Select Committee on Aging

COMPARISON OF USHEALTH PROGRAM ACT WITH CURRENT HEALTH CARE

The USHealth Program Act (H.R. 2980) takes the Medicare law and amends it in a way that expands Medicare to cover all Americans for the full range of health and long term care. The Act also contains a number of transition provisions to phase in USHealth.

ELIGIBILITY.

USHealth:

- All U.S. citizens and permanent residents are eligible for and covered by USHealth.
- For coverage beyond USHealth, private insurance available through employer or through individual purchase.

Current:

- Medicare limited to elderly and disabled. Medicaid limited to part of poor, elderly, and disabled. Private insurance available through employer or through individual purchase (except for uninsurable). Over 37 million people are uninsured and over 200 million are underinsured for long term care.

ENROLLMENT.

USHealth:

- Enrollment through Social Security offices. Other locations will likely be used as well. May allow option for enrollment by mail.
- Added cost of enrollment by Social Security is paid for out of USHealth trust fund.
- Initial enrollment and entitlement begins January 1, 1994.

Current:

- Mixed model of enrollment. Individuals enroll for private insurance through place of employment or insurance company. Medicaid eligible individuals enroll through State and county government. Medicare eligible individuals enroll through Social Security offices.

BENEFITS.

USHealth:

- The health and long term care package includes standard Medicare covered services as well as the following: inpatient hospital and inpatient psychiatric hospital services; medical and other health services; comprehensive outpatient rehabilitation facility services; MedCAF services; extended care and nursing facility services; skilled home health services; hospice; alcohol and drug abuse rehabilitation; outpatient mental health; services of clinical psychologist, clinical social worker, clinical nurse specialists, nurse practitioners; EPSDT; family planning; private duty nursing; physical, occupational, speech-language therapy; audiology; physical checkups, screening, immunizations, health risk reduction and preventive services; prescription drugs ($100 deductible) and other medical and remedial care recognized under State law and specified by USHealth. Dental care and eyeglasses covered no later than year 2000.

  Long term care is covered for chronically ill individual as follows: care management services; nursing care; services of a homemaker/home health aide; medical social services; physical, occupational, speech, respiratory and corrective therapy; medical supplies; patient and caregiver education; day health care; respite care; nursing facility services (as under Medicaid); limited transportation; and other personal care if authorized and within expected cost target.

Current:

- Mixed model based on type of coverage. Private insurance covers most acute care with deductibles and coinsurance but seldom covers long term care. Medicaid generally covers acute and long term care without deductibles and coinsurance. Medicare generally covers acute care with deductibles and coinsurance but does not cover services such as prevention, dental care, and long term care.

QUALITY ASSURANCE.

USHealth:

- Upgrades and expands quality assurance system to cover all patients and services, including ambulatory care, care management and home care services.
- Establishes a health and long term care ombudsman.
- Consumer role is expanded through consumer advisory board and hot-line.
- Establishes National Council on Quality Assurance.
- Secretary of DHHS provides annual reports on impact of cost containment on access, cost and quality.

Current:

- Mostly targets hospitals and nursing homes. Very little external QA for ambulatory or home care.
- Virtually no consumer involvement or access.
- No overall responsibility for quality assurance for nongovernmental beneficiaries.
- Very little investment in improving QA methods. Very little data available on impact of policy decisions on quality.

SERVICE PAYMENT AND COST CONTAINMENT.

USHealth:

- Single payer for everyone for all services.
- Overall national expenditure cap on health and long term care of 12% of GNP and on long term care of 1.1 % of GNP.
- Use prospectively set fees (DRGs for hospital care and non-DRGs for non-hospital care) for all care. Prospectively set fees should be developed in cooperation with respective provider group and should incorporate adjustments to account for patient differences and higher quality providers. Increases in the fees are limited to increases in per capita GNP. For hospitals, capital payments are made through a DRG specific add-on to the DRG payment.
- Encourage payment by HMO type capitation plan with HMOs getting 100% of average cost for enrollees.
- Provides for direct reimbursement of psychologists, clinical social workers, nurse practitioners and clinical nurse specialists.
- Payments serve as full payment to providers with no balanced billing allowed.
- States have option of a State alternative payment program with limited start-up funding and a limited share of Federal savings.
- Beneficiaries pay coinsurance but are protected from catastrophic costs as follows:
    - a. 20 percent of health, and skilled nursing home and home health costs up to a maximum of $600 per person per year (indexed to per capita GNP), and
    - b. 25 percent of non-skilled nursing home and home health costs up to a maximum of $1,000 per person per year (indexed to per capita GNP).
- Payment handled by insurance companies acting as carriers and intermediaries.
- Utilization review of all services by contract carriers and PROs.

Current:

- Multiple payers including Medicare, Medicaid, private insurers.
- Different payers for different services use somewhat different payment models, including fee for service, cost-based reimbursement, prospective payment and capitation. Payers using more and more similar methods in recent years.
- Very limited direct reimbursement of non-physician health professionals.
- Payment handled by insurance companies and fiscal intermediaries for Medicare, contract companies (e.g., insurance companies) for Medicaid, and insurance companies for employers and individuals.
- No overall cap on total health and long term care costs.
- Mixture of utilization review, payment freezes, fee schedules, competitive bidding, hospital DRGs, capitation.
- States have little cost containment role except for a) the Medicaid program and b) hospital payment regulation in several States.
- Medicare beneficiaries protected from the cost of catastrophic illness, but pay coinsurance. Privately insured have varied protection from cost of catastrophic illness. Medicaid beneficiaries protected from virtually all costs.

DELIVERY SYSTEM.

UHealth:

- Like current system with mix of public and private providers; HMOs (Health Maintenance Organizations) eligible for 100% of average cost as long as they provide full coverage including long term care.

Current:

- Mixed model of public and private health care providers with some growth in HMOs and ambulatory care.

FINANCING.

USHealth:

- Beneficiary cost-sharing subject to catastrophic limits.
- Savings from holding cost increases down to per capita GNP growth.
- "Medicare payroll tax" expanded to cover all income levels.
- A premium for those over age 65 approximating the cost of the "Medicare Part B premium payment" which may be waived for elderly below poverty level. Medicare catastrophic premiums and "surtax" are phased out.
- An employer tax on employee compensation utilizing a percentage which reflects the aggregate amount which employers are paying under the current system for employee and retiree benefits.
- Cigarette excise tax is raised by 16¢ and indexed to per capita GNP.
- State contribution equal on average to 1/2 cost of the poor (everyone under poverty level). Payment formula is as follows: (total cost of poor) X 1/2 X (State population / U.S. population) X (State per capita income / U.S. per capita income)
- Earmarked surcharge on all corporate and personal income taxes equal to the amount necessary to maintain the solvency of the USHealth Trust Fund.
- Revenues are placed in USHealth Program Trust Fund.

Current:

- Mixed financing for uninsured by charity; for private insurance by employers, employees, and individuals; for Medicare by premiums, federal payroll taxes and general revenues; and for Medicaid by federal general revenues and state general revenues.

NATIONAL HEALTH CARE REFORM

BACKGROUND PAPER

OVERVIEW

The debate about national health reform has extended over nearly three-fourths of a century. Teddy Roosevelt first made national health insurance a campaign issue in the Bull Moose campaign in 1912. Over the years, the issue has been on and off of the governmental and decision agenda. It received consideration from Franklin Delano Roosevelt during the New Deal period. Harry Truman proposed national health insurance in the late 1940s and 1950s. Medicare and Medicaid, health insurance for older persons and the poor, were passed in the mid 1960s. The idea of a more general national health insurance received considerable attention again in the late 1970s.

Currently, the growing problems of access to health care services within the United States -- 31 to 37 million people without any health care coverage (Fuchs, 1989), millions more with inadequate insurance (Farley, 1985), and continuing rising health care costs (Health Care Financing Review, 1987) have elevated the issue of "national" health care reform to higher agenda status during the 1st session of the 101st Congress. In addition, serious consideration of national health care reform will continue to dominate the national political agenda for the following reasons:

> Health care expenditures in the United States have increased for decades, both in aggregate terms and on a per capita basis as a percent of Gross National Product (GNP). In 1987, the latest year for which data are available, health care spending consumed 11.1% of the GNP, compared to 10.7% in 1986 and only 5.9% in 1965. Health care prices, as measured by the medical care component of the Consumer Price Index (CPI), are also increasing much faster than the overall rate of inflation.
>
> Current health care cost-containment initiatives within the United States' experience suggests that efforts to constrain expenditures by applying restraints on one part of the health care system tends to lead to ballooning costs in other parts.
>
> An overcapacity now exists almost everywhere in the general availability of acute care beds, physicians, and most allied health manpower, creating significant regional and local diseconomies, including previously inconceivable bankruptcies of hospitals (Battistella, 1989).
>
> An aging population is finding it increasingly difficult to pay for necessary health care services as Medicare deductibles and co-insurance costs continue to rise. In terms of out-of-pocket health care costs, the elderly spent 18.1% of their income for health care in 1988 (U.S. House Select Committee on Aging, 1989).

> The projected growth of the elderly population, combined with large and increasing public and private out-of-pocket expenditures for long-term care services has generated increasing interest in altering the way long-term care services are financed and delivered.
>
> Many in the American industry, are finding it increasingly difficult to pay for their employee's health care benefit packages. Rising health care costs are eating up wages, driving up the cost of doing business and reducing the ability of industry and manufactures to compete, both in the domestic and world markets.

Unequivocally, the growing problems within this nation's health care delivery system have stimulated the interest of policymakers, providers and consumers to reexamine the issue of national health care reform. National and comprehensive health care reform takes a variety of forms. This background paper will describe the provisions of several proposals and examine different concerns for each proposal, such as: administration, eligibility and enrollment, benefits, delivery system, cost containment, quality assurance and financing issues.

PROPOSALS

The following is not an all inclusive list of national health care reform proposals, but just a sample of various plans which represent very different approaches to reform and have received attention by the U.S. House Select Committee on Aging.

Several national health care reform proposals have surfaced during the 1st session of the 101st Congress. These proposals include:

* Congressman Roybal's USHealth Program Act -- H.R. 2980;
* Senator Kennedy's and Congressman Waxman's Basic Health Benefits for All Americans Act -- S. 768 and H.R. 1845;
* The National Leadership Commission on Health Care Proposal;
* The Health Security Partnership Plan; and
* Canada's National Medicare Model;

A comparison of the aforementioned proposals follows with an emphasis on the following questions:

* Who has responsibility for administration of the system?
* How comprehensive is the system in terms of access to care and scope of coverage?
* What will the delivery system look like?
* How will costs be controlled and who will pay?
* How will quality of care be monitored and assured?
* How will the system be financed?

WHO HAS RESPONSIBILITY FOR ADMINISTRATION OF THE SYSTEM?

The USHealth Program Act establishes a federal program based on Medicare and managed by the USHealth Administration, the current Health Care Financing Administration. It replaces Medicare, Medicaid and private insurance plans. The USHealth Program is independent and off-budget. Most bill processing and review will be provided through contracts with private insurance companies. The Basic Health Benefits for All Americans Act is a pluralistic health care system with a private-public partnership (Medicare, Medicaid, and private insurance) to assure care. Employers are required to cover their employees and Medicaid programs are expanded to cover the poor and near poor. The National Leadership Commission On Health Care Proposal retains the Medicare program and private insurance. The Federal government would provide guidelines for the Universal Access (UNAC) program but the program would not be centrally directed as is the Medicare program. The Health Security Partnership Plan retains the Medicare program with the remaining people being covered by a State system based within federal guidelines. Private Insurance would be continued in modified form, and may serve as qualified insurance delivery plans to be selected by employees and those not with an employer through which they may receive benefits. Medicare continues with its payment practices and standards integrated in the Health Security Partnership over time. The Canadian National Medicare Model is administered by ten Provincial governments which operate within the Canadian federal government's guidelines.

HOW COMPREHENSIVE IS THE SYSTEM IN TERMS OF ACCESS TO CARE AND SCOPE OF BENEFITS?

Within the USHealth Program Act financial access is ensured by making every citizen and permanent resident eligible. Enrollment in the USHealth Program is through the issuance of an account number either at time of birth or when issued a Social Security number. The basic health and long term care benefits includes standard Medicare covered services as well as the following: inpatient hospital and inpatient psychiatric hospital services, medical and other health services, comprehensive outpatient rehabilitation facility services, health care services of a medical care access facility, extended care and nursing facility services, skilled home health services, hospice, alcohol and drug abuse rehabilitation, and outpatient mental health services (including community mental health centers and state-authorized services provided by a clinical psychologist, clinical social worker, or psychiatric nurse specialist). In addition to the services traditionally covered by Medicare, medical and other health services are expanded to include: nurse practitioner and clinical nurse specialist services, Early and Periodic Screening, Diagnostic, and Treatment Program (for those under age 21), family planning, private duty nursing services, physical therapy, occupational therapy, speech-language therapy, audiology, and other medical or remedial care recognized under State law and specified by the USHealth program. Dental services, (including dentures), and eyeglasses are added before the year 2000 unless total USHealth expenditures would exceed 12 percent of GNP. Prescription drugs are covered with an annual deductible of $100. USHealth also covers physical checkups, health screening, immunizations, health risk reduction, and other preventive services.

Long term care (LTC) benefits are covered for chronically ill individuals (at least 2 age-appropriate ADL's or a similar level of cognitive impairment). LTC benifits include: care management services, nursing care, services of a homemaker/home health aide, medical social services, physical/occupational/speech/respiratory/corrective therapy, patient and caregiver education/training/counselling, day health care, respite care (minimum of 120 hours/year if eligible), nursing facility services (as under the current Medicaid program), medical supplies and limited transportation. Other LTC services, including personal care, may be covered if authorized by the care management agency and if total costs do not exceed expected cost.

The Basic Health Benefits for All Americans Act requires all working Americans and their dependents, as well as the uninsured to have basic health insurance. For Americans who are not covered by Medicare and unable to participate in employment based insurance, the legislation establishes a phased-in public Federal/State program to provide subsidized insurance coverage. The required benefits package must include medically necessary hospital care, physician care, diagnostic tests, prenatal care, well-baby care, and a limited mental health benefit. It must also include catastrophic coverage limiting out-of-pocket costs for covered services to $3,000 per family. And, finally the package may not contain exclusions from coverage based on health status or pre-existing conditions. This proposal does not submit a long-term care benefit package.

The National Leadership Commission On Health Care Proposal requires all Americans to have basic health insurance, whether obtained privately, publicly or by employer benefit plans. Older Americans would continue to receive Medicare coverage. The National Leadership Commission does not consider it appropriate for it to establish the original national basic benefits package for all Americans. They further assert that the initial package should be set by enabling legislation. However, the Commission recommends that mental health benefits and preventive services, especially prenatal care, be included in this package. They also recommend that once the national benefits package is determined, employers and individuals purchasing their own insurance would be free to supplement it. In addition, states could require that the basic level of benefits be higher for their residents, for both private and program beneficiaries.

The Commission did not specifically address long-term care. The Commission believes the urgent problems in long-term care should be addressed through the public-private partnership, shared responsibility approach which the Commission proposes for the overall health system.

The Health Security Partnership Plan provides universal coverage for all U.S. residents. Residents not covered by other plans would receive coverage by the programs offered in their state. The Medicaid program would be folded into this program. Medicare would continue to cover the elderly and the disabled. The basic benefits package to which all eligible individuals are entitled is comprehensive in nature. Nevertheless, states, employers, insurers, or Taft-Hartley health plans may choose to supplement the basic benefits package, which includes the following: inpatient and outpatient hospital care; inpatient and outpatient physicians' services; inpatient prescription drugs; diagnostic and screening tests; prenatal and well baby care; mental health services; substance abuse treatment programs; rehabilitative services; hospice care; post-hospital skilled nursing facility and home health services.

A beginning long-term care program which provides added benefits for those past the age of 65 and the disabled is to be inaugurated in the first phase. Limited institutional care for those requiring primarily custodial services and new personal care services provided at home are to be added in the first phase. In the second and third phases, eligibility is to be extended to those under the age of one, and then to the rest of the population. In phases two and three, the initial Medicare benefits will be expanded both as to age eligibility and length of benefits.

The Canadian National Medicare Model provides universal access to all legal residents of a province after a short waiting period. Comprehensive coverage includes all medically required services rendered by medical practitioners in hospitals, clinics or doctor's offices. Treatment by non-doctors, including occupational or physical therapists or nurse midwives is covered. Inpatient and outpatient hospital care, prescription drugs, diagnostic and lab tests, mental health care as well as preventive care including pre-natal and well-baby care are also covered. Limited dental care is available in some provinces. In contrast to Canada's well-established acute health care system, the financing and delivery of long-term care services is fragmented, with some coverage, but significant variation among the Provinces.

WHAT WILL THE DELIVERY SYSTEM LOOK LIKE?

To establish a comparative focal point, the current delivery system in the United States is a mixed model of public and private health care providers with some growth in Health Maintenance Organizations (HMOs) Preferred Provider Organizations (PPOs), Independent Practice Associations (IPAs) and ambulatory care systems. Within the USHealth Program Act, the delivery system would continue with a mixed model of public and private health care providers, however HMOs are encouraged and paid at 100 percent of the average area per capita cost. Medical Care Access Facilities (MedCAFs) are also part of the delivery system. MedCAFs are facilities which provides ambulatory, emergency, urgent, surgical care, basic inpatient care, radiology and laboratory services within a rural community.

The delivery systems are the same as the current delivery system for the Basic Health Benefits for All Americans Act, the National Leadership Commission On Health Care Proposal and the Health Security Partnership Plan. The Canadian National Medicare Model uses the same delivery system that was in place at the time the model was enacted.

HOW WILL COST BE CONTROLLED AND WHO WILL PAY?

The USHealth Program Act has several cost containment measures. First, the cost containment program covers all services and patients. Second, the cost containment provisions include paying all health care providers prospectively where payments are developed in consultation with providers. Third, future increases are limited to increases in the per capita GNP. Fourth, states may set up alternative payment programs if they choose and can perform as effectively as the federal program. Fifth, cost sharing of 20% for health and skilled long term care and 25% for non-skilled long term care is required, but only up to the specified catastrophic limits. The poor (under 100% poverty) and those spending down into poverty are exempt from any cost sharing which prevents access to needed care. The sixth cost controlled mechanism is a ceiling on total U.S. health costs of 12 percent of GNP. Under that ceiling is a ceiling on long term care costs set at 1.1 percent of GNP indexed to changes in severity, including assitance with activities of daily living and cognitive impairment.

The Basic Health Benefits for All Americans Act includes co-payments, deductibles and premiums for some beneficiaries. Medicare cost sharing would be the same as our current system. For other plans, co-payments, deductibles and premiums could be established at the state's option for individuals between 100% and 185% of the federal poverty level. No co-payments, deductibles, or premiums are permitted for individuals under 100% of poverty. Co-payments and deductibles, for public plan services for individuals under 100% of poverty who receive coverage from an employment-based plan will be paid by the public plan upon application by the individual. For this same group of individuals the public plan will also pick up the employee's share of the premium, if any, for individuals enrolled in employment-based coverage. For those in the public plan, employers will pay 80% of the premium, (average $1,295), except that employers must pay 100% of premium for lowest-paid workers, those earning up to 125% of minimum wage. Employees will pay 20% of the premium, meet a deductible of $250 for individual and $500 for family and pay 20% of expenses up to $3000; above $3000, the plan provides 100% catastrophic coverage. The plan also includes a cap on out-of-pocket health expenses. States would have the option of imposing an income-related out-of-pocket cap equal to a maximum of ten percent of income. Co-payments and deductibles for individuals above 185% of the poverty line would be set at the same levels as for private, employment-based plans. For the public plan participants, premiums would be set at the actuarial cost of coverage for all enrollees in the public program.

Cost containment measures utilized in the National Leadership Commission On Health Care Proposal are not specific but involve assigning responsibilities for all parties -- providers, patients, employers and employees, payers and insurers, the private and public sector, physicians and other health professionals, and federal and state governments. The Commission suggests that there is a need to create mechanisms e.g., a state agency, that encourage all parties to carry out their responsibilities. For the UNAC portion of the plan, the Commission endorses a state entity administering the program, complete with the power to negotiate with providers and practitioners to establish the package and payment policies for the program beneficiaries. Furthermore the Commission's approach to cost control would also be linked to its proposal for improving the quality and appropriateness of health care.

The Commission recommends another cost containment measure which involves the use of three major cost sharing mechanisms. The cost sharing mechanisms include deductibles, coinsurance and co-payments, and shared premiums. Deductibles are designed to offset the payout of the first covered benefit. The Commission recommends that state agencies design their UNAC programs with a flexible deductible system, e.g., no deductible for low income groups and higher deductible for those with higher income. Regarding coinsurance, the Commission recommends that the UNAC program design its coinsurance system more in line with the type of service provided rather than the site of care. As a model, the Commission suggested a coinsurance rate of 20% for most services and a rate of 50% for outpatient mental health services. On flat co-payments, the Commission offers two different recommendations. One approach is for state agencies to establish a flat co-payment scheme. To assist poor people in meeting these payments, the Commission recommends that state agencies limit the amount of out-of-pocket costs based on per capita income. Another alternative supported by the Commission, would be to limit out-of-pocket expenses to $1,000 per person and $3,0(per family for the national package of basic services only. Any additional expenses would be the responsibility of the individual or the individual's employer insurance plan. These out-of-pocket limits could be cut in half for those under the poverty level. Consistent with the Commission's Principles of Shared Responsibility and Universal Access, those beneficiaries above the 150 % of the poverty level would pay a premium, while those below would not. The Commission suggests that cost sharing in the private sector should parallel cost sharing provisions in the UNAC program, i.e., vary by income, for low-income employees.

Cost containment mechanisms in the Health Security Partnership Plan requires participation by federal, state and territorial governments as well as providers of services. Examples of the cost containment mechanisms include: biennial national and state budgets; special Congressional action required for increases in federal support beyond the growth in the national economy; payments to hospitals and nursing homes on biennially negotiated, prospectively budgeted basis; central control of state funds through a single state organization; payments to insurance companies and others to be on a capitated basis adjusted primarily by age and sex; payments to physicians by relative value schedule; balance billing prohibited for patients in the core program and mandatory assignment required for Medicare beneficiaries; incentives to move to organized group practice plans and provide improved benefits at competitive costs; a National Advisory Commission to address technological assessment and treatment effectiveness; state certification of insurers based on standards relating to cost, efficiency and quality of service; state standards for monitoring lengths of stay, preadmission testing, and other related quality and cost-effectiveness controls.

Several cost containment measures are utilized in the Canadian National Medicare Model. These cost containment measures are targeted at hospital budgets, physician services and administrative costs. The Provincial governments have implemented two cost controls to limit hospital spending. The first measure is targeting expenditures, or as it is called in Canada, "global budgeting." The Provincial governments decide on the funds they will allocate to each hospital for its operating budget, and if the hospital exceeds the budget, the deficit is paid by the Province and subtracted from the hospital's global budget for the following year. The second measure for containing costs involves regulating capital expenditures, including new equipment, new facilities, and renovations. Each Province bases its capital spending decisions on the needs of the aggregate population and attempts to eliminate waste by accurately forecasting the need for hospital beds and health services for the coming year.

Constraining physician services is another method of constraining costs' paid by the Provincial governments. The method for determining physicians' fees differs from that of hospitals. Physicians are paid on a fee-for-service plan, rather than by salaries. The relative weights of services in physicians' fee schedules are determined by the Provincial medical association, which then confers with its Provincial governments to determine the percentage increase of the overall fee schedule for each subsequent year. As the sole payer for physicians' services, however, the Provincial governments have the final word on how much to raise fees.

Another cost-saving feature includes lower administrative costs In Canada, organization and provider reimbursements are the responsibility of the Provincial governments. In the United States, private insurers incur these costs as well as the advertising and marketing costs of a competitive financing system (EBRI, 1989). For example, the administrative costs of the Canadian health care system were an estimated 0.11 percent of GNP in 1985, or about $15 per person (in U.S. dollars). This contrasts sharply with estimated U.S. administrative costs which amount to 0.66 percent of GNP, or about $106 per person.

HOW WILL QUALITY OF CARE BE MONITORED AND CONTROLLED?

In the USHealth Program Act the current Medicare quality assurance system, including Peer Review Organizations (PRO) and hospital and nursing home quality assurance is upgraded to place at least as much emphasis on quality assurance as on cost containment, cover all health care providers and consumers, cover all health services (hospital, physician, nursing home, home health, ambulatory centers), set up a national Council on Quality Assurance, add Consumer Boards to PROs, establish a patient bill of rights and create an ombudsman program. States have the option to develop their own qualified quality assurance system. If States establish their own plan of quality assurance they must provide at least the same level of protection as the federal plan. Quality assurance is also addressed through federal HMO qualification.

The Basic Health Benefits for All Americans Act assumes the current quality assurance system. Currently, quality assurance is primarily for hospitals and nursing homes and involves virtually no consumer involvement.

The National Leadership Commission On Health Care Proposal would greatly increase research on the appropriateness, effectiveness and quality of care and publicize the results to help patients, providers and payers assess treatment. The Commission also proposes a new unifying strategy for a National Quality Improvement Initiative to support and fund research on the appropriateness, effectiveness and quality of care. Such work would involve periodic collective priority setting, coordination, and progress evaluation, while maintaining decentralized activities. Finally, using the stimulating power of existing external review mechanisms of government and the private sector, the results of such work will be integrated into day-to-day clinical practice and into the decision-making processes of health care organizations.

Within the Health Security Partnership Plan national standards in partnership with the states will be established and monitored by the state programs to assure protection of quality. Each state and territory will certify insurers, HMOs, PPOs, and similar organizations which meet standards regarding cost, efficiency and quality of service. Each state and territory will be required to establish state standards, prior to biennial approval in the budget, for monitoring lengths of stay, preadmission testing (hospitals), and other related quality and cost effectiveness controls. A National Advisory Commission, funded by the federal government, will deal with technological assessment and recommendations relating to clinical treatment effectiveness. It will be authorized to meet regularly to make recommendations for possible inclusion of new technological procedures, discontinuance of payments for inefficient or wasteful procedures and other ineffective medical practices, and to develop consensus standards for major clinical treatments.

In the Canadian National Medicare Model there does not exist a uniform quality assurance system. Each Province has its own utilization review protocol which is delegated to physician representatives. In general, care in hospitals is reviewed by peer review committees of hospital physicians. The findings of these peer review committees are used internally and are not publicly released. Physicians are self-regulated by themselves and by the Provincial Colleges of Physicians and Surgeons. Penalties, such as denial of payment, fines, or suspension or termination of using the provincial billing number are employed if a physician is found negligent in his or her practice. The Provinces also have fraud detection systems which place random telephone calls to patients to verify medically necessary care. The media also seems to play a large role in "policing" quality of care issues within the Canadian Medicare Model.

HOW WILL THE SYSTEM BE FINANCED?

In order to finance the USHealth Program Act and to provide an orderly transition from the current system of financing health care, USHealth is financed through several revenue sources. Much of the long term cost of expanding access and reducing costs for all beneficiaries comes from reducing health care cost inflation for all health care providers. Health care costs savings are expanded by holding cost increases down to per capita growth in GNP --approximating the Nation's ability to pay. The bill's provisions are financed as follows: the savings generated by indexed prospective payment and capitation; beneficiary cost-sharing; an expanded cigarette tax; an extension of the Medicare payroll tax to all incomes; a premium paid by the elderly (approximating the "Medicare premiums"); an employer tax based on compensation; State revenues covering 1/2 the cost of the poor; and a surcharge on corporate and individual income taxes sufficient for the solvency of USHealth.

Financing of the Basic Health Benefits for All Americans Act builds on the current health care system's mixed model of employer paid plans, Medicare and Medicaid. Employers are required to provide health insurance for their employees and to pay most of the cost. Private regional insurance pools for small businesses are created. Small employers who experience excessive costs from complying with the mandate will be eligible for a Federal subsidy. The Federal Government requires that Medicaid cover the poor and near poor who are uninsured and will match eligible state expenditures for the program at Medicaid matching rates.

The plan proposed by the The National Leadership Commission On Health Care requires that all Americans have coverage for a national basic package of services. There are several ways they could obtain and finance this coverage. Most Americans would probably continue to obtain privately-financed coverage as an employment benefit, with the employer contributing most or all of the money for the premium. Any American could also choose to purchase this coverage with personal funds or could supplement the employer-provided coverage with personal funds. Older Americans would continue to receive Medicare coverage. Everyone else would receive public coverage through the UNAC program. The Commission calls for a shared responsibility in financing UNAC. Although Americans with incomes below 150 percent of the poverty level would have their premiums subsidized, they would be responsible for a small share of the costs of their care at the time of service. Employers who do not provide coverage to their employees would be required to pay a fee. This fee would finance the UNAC program to provide coverage to all uninsured workers and their dependents with incomes above 150 percent of the federal poverty level. Employers who offer a health plan would be exempt from the fee, if their plan provides the following: 1) provides at least the minimum national level of coverage; 2) limits the employee contribution for that coverage to no more than twenty-five percent of the total premium; and 3) extends coverage to all full-time workers. Employers who do not meet all three minimum standards would pay the full fee on all employees. The employer has the option of providing coverage to part-time workers who work less than 35 hours a week or to pay the fee for these workers, proportional to the hours worked. Special provisions are proposed for new businesses, small businesses, and new employees.

Self-employed persons who do not have health insurance will be required to pay both the employer fee and the individual fees. To relieve the burden on this group of workers, the Commission proposes to reduce the combined fee by the same proportion that the social security FICA rate is reduced for self-employed persons (FICA for self-employed persons is about 86.7 percent of the combined employer/employee payment for wage and salary workers).

In keeping with the dual Commission principles of shared responsibility and individual responsibility, the plan also calls for a fee to be paid by individuals who do not have employer-sponsored insurance. This individual fee would be levied on all uninsured individuals with incomes over 150 percent of the Federal poverty threshold. These individuals would, in turn, receive coverage under the UNAC program. The fee encourages individuals who have the opportunity to accept coverage from other sources to do so by exempting all covered persons from paying this fee.

The UNAC program would also provide health insurance coverage to all non-workers and all workers and their dependents with incomes below 150 percent of the Federal poverty level. All current Medicaid participants would be covered under UNAC. Health benefits provided to these individuals would be financed with: 1) State and Federal revenues that would have been expended under the current Medicaid program; and 2) an assessment on employers and individuals above 150 percent of the poverty level known as the Y health premium.

Within the Health Security Partnership Plan new revenue sources include payroll taxes on employers and employees, an employer tax based on compensation, increased private insurance premiums, alcohol and tobacco taxes, and other revenue sources the states may elect. Medicare will continue as a program for the foreseeable future and private, employer-based insurance will cover the employed. Substantial economies are expected through the reduction of waste in the delivery of services, ineffective treatment methods, and gradual decrease in administrative costs. It is expected that after the initial years of organization and inclusion of beneficiaries now without protection, the annual federal and state cost increases will not exceed growth in the national economy. The national Health Security Partnership trust funds will be separate from the federal budget. Income and expenditures are expected to balance each year.

The Canadian federal and provincial governments share the financing of health care for the Canadian National Medicare Model. The federal share comes primarily from income taxes, as does the provincial share. In all provinces, general tax revenues support most or all of the costs of hospital and physician care.

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STATEMENT OF REPRESENTATIVE BILL SCHUETTE

Mr. SCHUETTE. Thank you, Mr. Chairman. I certainly want to commend you for the timeliness of this hearing, and it certainly is most appropriate that we commence receiving differing views and different approaches to the challenges that America faces in terms of health care delivery in the years ahead.

Certainly, the focus for this hearing and certainly countless others that will occur within various rooms, here and across the country, ought to be making sure that affordability and quality are at the lynch pins of what we need to do in terms of health care services for America's future. Those ought to be the two goals—sometimes in conflict, sometimes competing—but certainly both must be attained.

I see we have a distinguished group of panelists today, and certainly want to pay my utmost respects to Doug Fraser. He is certainly a leader in my State of Michigan and across the country. Mr. Fraser, good morning to you, sir.

The other panelists—and certainly Debbie Steelman, who I know well from past activities, good morning to you, madame, as well.

I have an Agriculture Committee meeting and, Mr. Chairman, I will try to return, but I certainly appreciate the presence of our panelists, and you sir, for conducting this hearing.

Mr. ROYBAL. I thank you. The Chair recognizes Ms. Meyers.

STATEMENT OF REPRESENTATIVE JAN MEYERS

Ms. MEYERS. Thank you, Mr. Chairman. When you talk about the problem of health care in this country, you are really almost talking about multiple problems. Certainly for the elderly there is the problem of acute care, which we recently tried to address in the Catastrophic Care bill.

I think we did it badly. It was mostly unacceptable to the American people. I think we will repeal, or mostly repeal that, and probably try to address it again in a different way.

However, I must say that I have some concerns about the cost of supplementary insurance, if we repeal the Catastrophic Care bill totally. I'm sure that that will be brought out by some of our panelists this morning.

We have the problem of the uninsured. There is catastrophic care for the young, as well as for the elderly. Certainly, Mr. Schuette mentioned affordability of care and quality of care, but in addition to that, in the rural areas of this country, we have the problem of access to care.

So, there is certainly no shortage of problems, and I look forward to the testimony. I, too, have a competing Committee meeting in Foreign Affairs, and so will stay for awhile, and will read the rest of the testimony and look forward to hearing from our panelists.

Mr. ROYBAL. Thank you. The Chair recognizes Ms. Morella.

STATEMENT OF REPRESENTATIVE CONSTANCE A. MORELLA

Ms. MORELLA. Thank you very much. Mr. Chairman, I, again, join my colleagues in thanking you for your leadership in this field. You have always been there, from the time I was elected to Congress, and this is a very appropriate hearing.

We certainly are at a critical point in the history of the American health care delivery system. Escalating costs, the growing problems of lack of accessibility to quality health care, and the increasing needs of our aging population, illustrate full well the need to examine and evaluate new alternatives in the pursuit of a system that can meet the expanding health care needs of the American public.

Whether a broad-based national reform strategy should be developed, as opposed to a more incremental approach, is certainly a major question which should be addressed.

The expert witnesses that we have before us today will discuss four different approaches for comprehensive Nation-wide reform of health and long term care in the United States. They will provide us with a look at the alternatives, which are intended to assure quality of health and long term care for everyone.

It is my hope that through the testimony today from these and other expert witnesses, we will gain the necessary insight to make informed, accurate decisions as we work toward a health care solution that will benefit every citizen.

So, I thank you, Mr. Chairman, for calling the hearing. I look forward to hearing from the witnesses, and I hope you will note on this side of the aisle, the intense interest that we all have, Mr. Chairman. Thank you.

Mr. Roybal. May I say that I took note of that a few minutes ago. The Chair now recognizes Mr. Boehlert.

STATEMENT OF REPRESENTATIVE SHERWOOD L. BOEHLERT

Mr. Boehlert. Thank you, Mr. Chairman. I really appreciate your leadership in this important area, and I am pleased to see the very distinguished panel that we have before us.

I am somewhat frustrated, and I'm frustrated because we are all apologizing as we welcome you, and then taking our leave. In my case, I have to be a ranking member of the Investigations and Oversight Committee of Public Works.

Former Congressman Rogers can appreciate this. We are getting more like the Senate every day, and that is bad for America. We are supposed to be 38 different places at once.

The purpose of this hearing is right on target. It is really important. I happen to be one of those who voted and spoke out strongly against repeal of catastrophic health insurance. When people asked me what Congress should do now, my response was, apologize to the American people for turning our back on responsibility and, in the process, ignoring the legitimate health care needs of millions of elderly Americans.

That is history now as far as the House is concerned. I just hope that we can get some insight from these very distinguished panelists that will guide us in the right direction. There is a lot of rhetoric around this town. We talk about the elderly. We say we want to address their needs and do so in a comprehensive way. But, quite frankly, I think too often we walk away from that responsibility.

I'd like to commend the Chairman and his leadership because he is not one of those who walks away. I hope I am not going to be one of them who walk away.

I wish to assure all the panelists that I will very carefully read your full testimony. You are all experts. I know you by reputation. Some I have been privileged to meet personally. I thank you for sharing with us your special insight in a very, very important area.

I'm telling you this—I am tired of apologizing for our inactivity in Congress. I'd like to start bragging about the good things we do. Thank you.

Mr. **Roybal**. Thank you. The Chair recognizes Mr. Duncan.

Mr. **Duncan**. Thank you, Mr. Chairman. I really have no opening statement. This is a very important subject, and I am anxious to hear the witnesses.

Mr. **Roybal**. I thank you, sir. At this time, if there are no objections, I would like to submit the prepared statements of several of our colleagues for the hearing record. Hearing no objections, so ordered.

[The prepared statements of Representatives Waxman, Bilbray, Costello, DeFazio, Saxton, Bentley, and James follows:]

STATEMENT BY THE HONORABLE
HENRY A. WAXMAN
CHAIRMAN
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE

ON
THE "BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT"

Today the United States stands alone with South Africa as the only industrialized country in the world without a comprehensive health insurance system. Nearly a quarter of a century ago we enacted Medicare to fill in the gap after people left their employment and lost their insurance, and Medicaid to help the neediest. Over fifteen years have elapsed since President Nixon declared a crisis in health care and proposed a national plan. A decade ago President Carter was pressing for comprehensive health care reforms.

In spite of all these warnings, no national programs have been enacted. The time for preventive action came years ago. Now we must deal with the consequences of inaction. Those consequences are, sadly, that the situation has gotten worse, not better.

This situation is no less than a challenge to all of us to face up to the difficult and tragic problems our nation now faces in health care:

> Some 37 million Americans have no health insurance. All too often, they are denied basic health care. In plain and simple terms, this is a national disgrace.
>
> Forty years of progress in expanding health insurance coverage through employment-related insurance, Medicare, and Medicaid has now been reversed. During the 1980s, the number of uninsured grew by one million each year. This is intolerable and it must end now.
>
> Even more ominous, public confidence in our private health insurance system is being undermined by the practices of many insurance companies and self-insured plans. Over and over, people with insurance -- especially in small businesses -- are now discovering that the health insurance they have paid for and counted on may very well not be there when they get sick and need it. If private health insurance is to survive, this must stop.
>
> After years and years of staggering increases in health care spending we still have desperate problems with infant mortality and AIDS, we still have inadequate levels of prenatal care and immunizations, we have less and less access to emergency and trauma care, and we have prescription drugs and medical technologies that are so expensive we hear talk about rationing care for those who cannot afford to pay.

People are sick and tired. Sick of our health care system, and tired of dealing with its complexity. Unprecedented numbers of Americans are now calling for fundamental changes in our health care system. Over the last year or so, we have seen a new wave of concern -- not just here in the Congress -- but among businesses and health care providers and community leaders. The cries are coming from all sectors -- from the general public, from workers, from big business, from health care providers.

> The Harris Poll tells us that 89% -- eighty-nine percent -- of Americans believe our system requires fundamental change or complete rebuilding.
>
> The Wall Street Journal highlights the crisis facing small businesses
>
> Private citizens plead for relief from the Congress as more and more insurance companies deny payment for people who thought they were covered.

As the Subcommittee on Health and the Environment has looked into these growing crises, we have heard directly from citizens who have suffered:

--A mother testified about the illnesses her children have endured because they had no insurance

--Another woman who has been almost continually employed described her agony and terror as she faced life-threatening illnesses without insurance coverage

--A woman sought legal help when her employer kept her from returning to work after an illness until she was considered a "new" employee with a "preexisting condition" that is now excluded from coverage

--A worker was healthy and covered by insurance but got seriously ill and when the insurance ran out discovered that she is now "uninsurable" for the rest of her life

--A family with good jobs and health insurance had a sick child and the insurance company squeezed them out of coverage by quadrupling their employer's premiums

No wonder the cries for relief are increasing. We have inadequate coverage for those who we thought would be covered by private insurance. Others are without health care coverage at all. Businesses are caught between insurers and providers who raise rates over and over, and workers who pay more and more out of pocket.

When uninsured people get sick and manage to get health care, somebody ends up paying the bill. Public hospitals and public programs are drained. Private hospitals and doctors must charge people with good insurance more to make up for what they don't collect from people with inadequate coverage. That runs up the health care bills for companies that provide health benefits for their own workers.

This situation is not fair. It's not fair to taxpayers, and it's not fair to businesses that are good citizens and provide health benefits.

These are problems that are not new. But they are getting worse. A common recognition of the problem can lead to the consensus we need -- as a society -- to act.

What we need to do is spread the cost of covering workers across all employers, and spread the risk of illness fairly among insurance companies.

To accomplish these goals, I have introduced H.R. 1845, the "Basic Health Benefits for All Americans Act."

Under this bill, employers must offer, and full-time workers must accept, health insurance coverage that meets minimum standards. Health insurance plans are required to be marketed in a way that will assure adequate coverage at fair prices. Persons not covered through an employer will be incorporated into an expanded and improved Medicaid program. The program is phased in so that everyone is covered by the year 2000.

This legislation forces us to face the fact that if we're going to have an employment-based system of health care coverage in this country, we have to make sure that all employers pay their fair share. And, if we're going to rely on private health insurance companies, we have to make sure that they charge fair rates and provide adequate coverage when people need it.

This legislation forces us to ask what is fair to expect of employers.

It's one thing to ask the public to pay for covering those who are outside of the employment-based system. But it's another thing to ask the public to bear the burden for businesses that don't provide health insurance to their workers when they could.

This legislation also forces us to face the task of defining and providing for a public program to cover everyone who is left without insurance after employers have all done what is fair.

Last year we joined with Senator Kennedy in introducing the "Minimum Health Benefits for All Workers Act." That bill would have required all employers to provide insurance for their workers. It would have ended the nightmare facing small businesses. I always viewed that legislation as one piece of our efforts to assure decent health care for all Americans. We learned a lot from our hearings on that proposal. But the debate over that bill focused only on its potential impact on employers, and to some degree we lost sight of the bigger picture.

Now we must enact a comprehensive solution to these pressing problems. It is our expectation that we can achieve the necessary consensus and legislation can be enacted during this Congress. These problems are too serious, and affect too many peoples' lives, to wait longer for solution.

BRIEF SUMMARY: "Basic Health Benefits for All Americans Act"
H.R. 1845
Subcommittee on Health and the Environment
Henry A. Waxman, Chairman
April 12, 1989

EMPLOYERS ARE REQUIRED TO OFFER HEALTH INSURANCE

-- regardless of their size, employers must offer either the minimum plan specified in bill or a plan that is the actuarial equivalent

-- employers who currently provide health insurance may be affected by the benefit requirements, but should be able to meet the cost-sharing requirements through the actuarial equivalence provision

-- special provisions phase in the requirements slowly for small businesses, permit a limited plan to be offered for an initial period, and assist companies who would experience unusual financial stresses

FULL-TIME WORKERS MUST ACCEPT INSURANCE COVERAGE

-- nearly all workers and their families would be covered

-- full-time workers (25 hours/ week) must accept coverage for themselves; they can refuse coverage for spouse and children who are covered by another employer plan, but their primary insurance must be through their own workplace

-- part-time workers (17.5 - 25 hours/week) may refuse coverage, but can be eligible for the public plan based on their incomes

BENEFITS

-- basic package: medically necessary hospital care, physician services, prenatal care, well-baby care, laboratory and x-ray; a typical package of mental health benefits is also included

-- current exclusions: prescription drugs, preventive care, long-term care

COST AND COST-SHARING

-- estimated premium is $1,619/year, averaging individual ($883) and family ($2,241) rates

-- employer pays 80% of premium (average, $1,295), except that employers must pay 100% of premium for lowest-paid workers, those earning up to 125% of minimum wage

-- employee must pay 20% of premium, meet a deductible of $250 for individual and $500 for family, and pay 20% of expenses up to $3,000; above $3,000, plan provides 100% catastrophic coverage

-- prenatal and well-baby care are first-dollar coverage, with no deductible or co-payment

INSURANCE PROVISIONS

-- no pre-existing condition exclusions will be allowed

-- state mandates on insurance policies are overridden

-- country divided into 6-8 regions

-- all insurers who wish to sell plans in each region must meet criteria established by the Secretary of the Department of Health and Human Services

-- each insurer must offer a basic plan that meets standards of bill, and a more comprehensive package; plans are to be offered in both indemnity and managed-care options

-- within each region, each carrier must community-rate all plans so that all employers will be treated alike by a given plan; some inter-state variation of community rate is permitted

-- insurers can form networks with other insurers or HMOs or other carriers

PUBLIC PROGRAM

-- three stage phase-in for coverage of those who are not full-time employees:

January 1, 1991: Everyone below poverty is covered; States may cover those between 100 and 185% of poverty.

January 1, 1996: States must cover everyone below 185% of poverty

January 1, 1999: States must cover everyone

-- Benefits: same as for employer public program

exception -- EPSDT mandatory, prescription drugs optional

-- Reimbursement: Raised to Medicare levels for both new program and all existing Medicaid beneficiaries

January 1, 1991: Physician services raised to Medicare

January 1, 1996: All other services raised to Medicare

-- Financing: Same as current Medicaid

OPENING STATEMENT OF THE HONORABLE JAMES H. BILBRAY FOR THE HOUSE SELECT COMMITTEE ON AGING,

NOVEMBER 9, 1989

MR. CHAIRMAN, THANK YOU FOR CALLING THIS VERY MUCH NEEDED HEARING ON OUR NATION'S HEALTHCARE SYSTEM. OVER THE PAST FEW YEARS, IT HAS BECOME CLEAR THAT WE MUST DO SOMETHING TO REFORM OUR HEALTHCARE SYSTEM. HEALTHCARE COSTS CONTINUE TO RISE AT RATES THAT ARE TWO TO THREE TIMES OVER THE ANNUAL INCREASE IN THE INFLATION RATE, WHILE INCREASING NUMBERS OF AMERICANS FIND THAT THEY DO NOT

HAVE ACCESS TO ADEQUATE HEALTHCARE. 37 MILLION AMERICANS CURRENTLY HAVE NO HEALTH INSURANCE, AND IN MANY STATES, MEDICAID ONLY REACHES ABOUT HALF OF THE PEOPLE WHO ARE ELIGIBLE FOR IT.

MR. CHAIRMAN, THE RECENT EXPERIENCE THAT WE HAVE HAD WITH THE MEDICARE CATASTROPHIC ILLNESS PROGRAM VERY WELL PROVES YOUR POINT THAT THE TIME HAS PASSED FOR PIECEMEAL SOLUTIONS TO THIS CRISIS. IT IS TIME FOR US TO ENACT A COMPREHENSIVE HEALTHCARE PLAN THAT WILL ADDRESS THE NEEDS OF ALL AMERICANS. WE NEED LONG TERM CARE

FOR OLDER AMERICANS, BETTER PRE-NATAL AND POST-NATAL CARE FOR POOR MOTHERS AND THEIR CHILDREN, AND MORE PREVENTIVE MEDICINE FOR ALL AMERICANS.

I FEEL THAT WE ARE APPROACHING A CRITICAL TIME WHEN IT MAY AT LAST BE POLITICALLY FEASIBLE TO ENACT SUCH A COMPREHENSIVE PROGRAM. JUST A DECADE AGO, A NATIONAL HEALTH PLAN WAS DISMISSED BY MANY AS BEING JUST ANOTHER BUDGET-BUSTING LIBERAL BOONDOGGLE. HOWEVER, I BELIEVE THAT THE UNPRECEDENTED RISE IN HEALTH CARE COSTS THAT WE HAVE EXPERIENCED

DURING THE 1980'S MAKES THE SITUATION RIPE FOR PULLING TOGETHER A UNIQUE COALITION OF BUSINESS, LABOR, SENIOR CITIZENS, AND THE UNINSURED, TO SUPPORT A NATIONAL HEALTH PROGRAM.

INDEED, IF HEALTH CARE COSTS CONTINUE TO SPIRAL UPWARD AT THEIR CURRENT RATE, WE ARE GOING TO SEE A NOTICEABLE DROP IN THE STANDARD OF LIVING FOR MOST AMERICANS, AND OUR TRADE IMBALANCE WILL DETERIORATE EVEN FURTHER. CHRYSLER ESTIMATES THAT EMPLOYEE HEALTH COSTS ADD $700 TO THE PRICE OF EVERY NEW CAR--HOW LONG CAN A COMPANY CONTINUE TO BEAR

THESE MASSIVE HEALTHCARE COSTS AND REMAIN COMPETITIVE IN TODAY'S WORLD?

MR. CHAIRMAN, WE MUST SEIZE THIS OPPORTUNITY TO PUT TOGETHER THIS COALITION AND ENACT THE HEALTH PROGRAM THAT OUR COUNTRY NEEDS SO BADLY.

OPENING STATEMENT BY
U.S. REPRESENTATIVE JERRY COSTELLO
NOVEMBER 9, 1989
"BUILDING AN AMERICAN HEALTH SYSTEM"

This mornings hearing on "Building an American Health System" is an issue of great concern to older Americans. I know a great number of people in my Congressional District would profit from an enhanced health sytem.

I want to thank you, Mr. Chairman for your leadership in this area and forholding this important hearing. As we head into the 90's there is no more crucial issue than ensuring the health of our Senior Citizens.

I would also like to thank today's distinguished witnesses for appearing here today. I look forward to reviewing their testimony. Thank you.

PREPARED STATEMENT OF REPRESENTATIVE PETER A. DeFAZIO

Mr. Chairman: It's a pleasure to be here today. As one of the newest members of the Aging Committee, and as far as I know, few members with formal training and experience in gerontology, I hope I have something to offer to today's discussion.

I agree with the statements of other members of the Committee that, our recent experience with the Catastrophic Coverage Act is evidence of our failed attempts at piecemeal approaches to reform of the health care delivery system in this country. In the year since passage of the Act, we still don't know how much the Act would cost and which benefits are most needed.

The bottom line is, health care should be a right, not privilege. We must find affordable comprehensive solutions, not only for America's seniors, but for all Americans. Every other industrialized nation in the world, except South Africa, has a national health care system.

We can do better. We must do better. Today's hearing is an important step toward getting there.

STATEMENT OF CONGRESSMAN H. JAMES SAXTON
SELECT COMMITTEE ON AGING
NOVEMBER 9, 1989

I WOULD LIKE TO THANK OUR DISTINGUISHED CHAIRMAN, MR. ROYBAL AND MY GOOD FRIEND AND COLLEAGUE FROM THE GARDEN STATE, MR. RINALDO, FOR GATHERING US HERE TODAY TO EXAMINE THE GAPS IN OUR CURRENT HEALTH CARE DELIVERY SYSTEM.

PERHAPS THE ONE BRIGHT SIDE OF THE DEBATE OVER THE CATASTROPHIC COVERAGE ACT IS THAT IT HAS BROUGHT NEW AND SERIOUS ATTENTION TO THESE GAPS IN MEDICAL COVERAGE. OLDER AMERICANS WILL BE LOOKING TO US IN THE COMING YEAR FOR REFORM IN THIS AREA AND I AM PLEASED THAT WE ARE BEGINNING DISCUSSIONS TODAY.

THE WINDS OF CHANGE ARE BLOWING IN CONGRESS. YESTERDAY THE HOUSE - AGAIN - SHOWED THAT THE 'CAT' MUST GO BY VOTING FOR AN ALL OUT REPEAL OF MEDICARE CATASTROPHIC COVERAGE ACT.

AND THAT'S WHY WE ARE HERE TODAY. TO EXAMINE THE PROPOSALS THAT HAVE BEEN INTRODUCED BY MY COLLEAGUES AS WELL AS OTHER METHODS USED IN FOREIGN COUNTRY'S.

YESTERDAY IN HOUSE ACTION I EXPRESSED THAT WE MUST ROLL UP OUR SHIRT SLEEVES AND BEGIN TO ATTACK THE REAL ISSUE THREATENING THE POCKETBOOK OF SENIORS, THAT OF LONG TERM CARE COVERAGE.

I AM PLEASED IN HOW QUICK MY WORDS TOOK ACTION - HOWEVER I WANT TO EXPRESS SOME CONCERN.

AS CITIZENS OF THE U.S. AND HEALTH CARE CONSUMERS WE EXPECT AND DEMAND THE BEST HEALTH CARE. AS WE EXAMINE THESE DIFFERENT MODELS OF REFORM, I SUGGEST WE USE CAUTION IN APPLYING THESE TO OUR SYSTEM.

FOR EXAMPLE, ALTHOUGH WE CAN LOOK AT THE CANADIAN HEALTH CARE SYSTEM, IT IS ON A DIFFERENT SCALE THAT WE MUST EXAMINE THEIR METHOD.

IT WOULD BE DIFFICULT AT BEST TO JUDGE WHETHER A GOVERNMENT RUN INSURANCE SYSTEM WITH 25 MILLION ENROLLES - A POPULATION SMALLER THAN THAT OF CALIFORNIA - COULD BE SUCCESSFUL IF EXPANDED 10 TIMES TO REACH 236 MILLION UNITED STATES RESIDENCE.

ALSO I EXPRESS CONCERN ON THE QUALITY OF HEALTH CARE THAT WOULD BE AVAILABLE FOR OUR CITIZENS.

SOME TYPES OF HEALTH CARE HAS BEEN RESTRICTED DUE TO BUDGET CONSTRAINS OR LONG DELAYS FOR CERTAIN SPECIALTY SERVICES IN THE CANADIAN SYSTEM.

IN FEBRUARY OF THIS YEAR, A CANADIAN PAPER, THE OTTAWA CITIZEN, REPORTED THAT TWENTY FOUR PEOPLE DIED IN BRITISH COLUMBIA LAST YEAR WHILE AWAITING HEART SURGERY.

PROBLEMS RANGE FROM LACK OF INCENTIVES FOR HOSPITALS TO TREAT EVERY POSSIBLE PATIENT, THE RELATIVE SHORTAGE OF SPECIALISTS, THE INSUFFICIENT RESOURCES WITH SACRIFICES OF QUALITY ASSOCIATED WITH THE SLOW ADOPTION OF NEW TECHNOLOGY.

EXPERTS ALSO QUESTION WHETHER THERE IS ANY CLEAR RELATIONSHIP BETWEEN THE NATIONAL HEALTH INSURANCE SYSTEM AND BETTER HEALTH.

THE DIAGNOSIS LEADS ME TO BELIEVE THAT OUR CITIZENS WOULD NOT WANT A SYSTEM WHERE THEY WERE LEFT TO FILL THE PRESCRIPTION.

THERE IS NO QUESTION THAT OUR CURRENT SYSTEM IS IN NEED OF DRASTIC TREATMENT. I AM PLEASED TO JOIN MY COLLEAGUES HERE TO BEGIN TO ANALYZE THE ISSUES IN ORDER TO WORK TOWARD A REMEDY FOR OUR AILING, EXPENSIVE HEALTH CARE DELIVERY SYSTEM.

OPENING STATEMENT
BY THE
HONORABLE HELEN DELICH BENTLEY
FOR THE
SELECT COMMITTEE ON AGING HEARING
"BUILDING AN AMERICAN HEALTH SYSTEM"
NOVEMBER 9, 1989

Good morning, its a pleasure to be here today to discuss an issue of great importance to us all. If there are two things that the people in this room can agree upon, its that we want to adjourn before Thanksgiving and that health care in the United States is at a critical crossroads. There is no doubt in my mind that our present system has deep-seated, far-reaching problems that require careful scrutiny.

Todays hearing will give us an opportunity to review a number of substantive national health care proposals. I have reviewed a number of these reports --- not to mention their dissenting opinions. In particular, I recall a heated debate that took place last summer in Health Affairs journal, between members of one commission that is represented here today. My recollection is that one group participant, the USX Corporation, disassociated itself from the commission before its final report was even issued.

Now, I only use this example to illustrate the difficulty of reaching a consensus on the direction of our national health care policy --- not to demean the integrity of any commission or its participants. There is alot of groundbreaking work taking place and I commend them for taking on this thankless task. Thus Mr. Chairman, I'm very pleased that you have scheduled this hearing -- I look forward to the witnesses testimony.

OPENING STATEMENT OF CONGRESSMAN CRAIG T. JAMES
HOUSE SELECT COMMITTEE ON AGING
NOVEMBER 9, 1989

THANK YOU, MR. CHAIRMAN, FOR THIS OPPORTUNITY TO SAY A FEW WORDS.

TODAY'S HEARING, "BUILDING AN AMERICAN HEALTH SYSTEM," CERTAINLY IS FOCUSING ON A VITALLY IMPORTANT TOPIC. SURELY THERE IS A ONLY LIMITED NUMBER OF ISSUES THAT OUTWEIGH THE IMPORTANCE OF HEALTH CARE. NEEDLESS TO SAY, HEALTH CARE SERVICES ARE PARTICULARLY CRUCIAL TO OUR NATION'S OLDER AMERICANS.

AS THE POSITIVE AND NEGATIVE ATTRIBUTES OF AMERICAN HEALTH CARE RECEIVE INCREASING SCRUTINY, TODAY'S HEARING WILL CERTAINLY BE HELPFUL TO OUR PANEL'S WORK IN THIS AREA. IN THIS REGARD, I WANT TO EXTEND A PERSONAL WELCOME AND EXPRESSION OF APPRECIATION TO THE FINE WITNESSES FROM WHOM WE ARE ABOUT TO HEAR.

THANK YOU.

Mr. ROYBAL. Our first witness today is the Honorable Paul G. Rogers, who at one time, was our colleague here in the House of Representatives, and was the Chairman of the Subcommittee on Health and the Environment, Committee on Energy and Commerce.

He joins us today in his role as Cochair of the National Leadership Commission on Health Care. Mr. Rogers is an expert in his field, and the Chair will recognize him first to proceed in any manner that he may desire.

STATEMENT OF PAUL G. ROGERS, CO-CHAIRMAN, NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE

Mr. ROGERS. Thank you, very much Mr. Chairman and members of the Committee. I am very pleased to be here. You are addressing a most important subject, and I commend you, Mr. Chairman, for beginning this process here. Other Committees, I am sure, are going to have to do this—follow your lead. Some have started.

The Congress is going to have to address this problem. We have available in our Nation, the best health care in the world. You can get care, but it's costing too much. So much of it is not of proper quality. People often don't have access to many people.

So, the National Leadership Commission on Health Care, which I cochaired with Governor Ray of Iowa, brought together a cross-section of the American public—industry, labor, health professionals, experts, consumers—and we studied this problem for 2½ years.

We have made our report, which I am sure has been furnished to the Committee, and the main thrust I think we felt was that whatever we do, it has got to be a systemic approach. This patching business that we have been going with for so long in this country—putting something there, maybe trying to fix it here—instead of looking at the system and doing something overall—I'm delighted that the Chairman in his bill has taken that systemic approach rather than just say we're going to do a little something here or there.

As we studied, of course, we recognized the same problems that you have. I only have 7 minutes here, so I'll just highlight a few things if I may.

Rising costs—of course, you know, that is constant with us. For instance, I think by the year 2000, it will probably be $1.5 trillion—the health care bill for the Nation. We are now a little over 11 percent of the Gross National Product. It is constantly growing and multiplying.

Limited access—some 37 million don't have proper health insurance—can't really get into the system. It is estimated many more than that don't have adequate coverage. There is no reason for that in this Nation. Eleven million of those, incidentally, are children.

Uncertain quality—this is something I have never zeroed in on until we got into these hearings, and we heard experts like Dr. Wennberg of Dartmouth, Brook of the RAND Corporation, Eddy of Duke, who have done studies on the quality of health care.

You know, I had always thought every procedure the doctor does had been researched, checked out. That is not true.

Now, in drugs, the Congress has required some research, and they have to know what is going to happen. That is not true with medical procedures.

Quality is a most important factor that really must be addressed. Another item that I think the Congress is not giving enough attention to, nor do most people when they talk about this, and that is the malpractice problem.

Consider cost—malpractice threats increase it—because it is defensive medicine. I'm not talking about the cost that the doctor has to pay for health insurance coverage to protect himself. That is expensive, too. The fact that doctors do all of these tests and procedures to protect themselves, and that brings automatic increases in costs across the board. There is no telling how much that costs the American public.

So, these are the main problems, and I know this Committee will address them. I hope you will also take into consideration action on malpractice.

Now, the Leadership Commission felt we should have universal access, and we do that in our report—I won't go into great details because we have submitted a lengthy statement.

We do set up State programs to take the place of Medicaid, so that those who are not covered, would be covered there. We allow that State agency—we call it Universal Access (UNAC)—for those who cannot pay, below the poverty area, they can join UNAC. The individual in our plan would have the responsibility of getting insurance.

The individual—we would put more responsibility on the individual and try and get the individual, also, to assume more responsibility for one's own care. That is another subject. But if the individual cannot get health insurance from his employer, and we also think that is pretty well established in this country already—that industry, for the most part, is providing health insurance for its employees. Then the individual can buy his or her own insurance. If they can't purchase it, they can join UNAC.

If industry doesn't provide insurance, we would provide that companies should pay a fee of 9 percent up to Social Security level income, and the individual would pay 2 percent, the employee.

Now, all Americans, in order to provide for Universal Access, would be asked to pay .6 percent of their income up to the Social Security level. So, that is one way.

Now, we think costs, of course, need to be addressed. We feel that if we have the UNAC plans they will negotiate the fees with the medical professions in those States, you will see a lowering of cost. We also think that one of the most dramatic ways we can save money, is an improvement of quality, and doing away with unnecessary procedures.

For instance, they may show that one procedure in one county may be 7 times as great as that same procedure done in an adjoining country—7 times.

Dr. Wenberg studied Boston and New Haven—two pretty good places for medical care—and he found that procedures would be twice as much in one community as in the other. The costs were amazingly different.

So, this whole process of how we deliver care, the quality and how it is done, needs to be looked at. We feel, and we hope you would consider, setting up research on "quality." It is going to have to be funded, and that is why we ask everybody to pay in America, .6 percent up to the Social Security level.

A portion of that, about 1 percent of that .6 percent, we think would cover the amount of research that needs to be done on quality. It would be done by the medical professions in the medical research centers of the country.

Then, you would have guidelines. It is estimated that the 70 major medical procedures that we do in this country account for about 50 percent of the costs. So, we are spending a little over $600 billion. That is about $300 billion for 70 procedures.

For getting started, we would phase in as the research is done and guidelines are established—guidelines established Nationwide. It is estimated that in 4 years, very conservatively, we'd save over $84 billion by doing away with unnecessary procedures.

Dr. Bud Relman, who is Editor of the New England Journal, has estimated that up to 20 to 30 percent of procedures are unnecessary—should never have been done. The RAND Corporation also did studies and I think they estimate 14 to 32 percent. It is amazing—procedures that we are paying for that are not really necessary, nor should be done.

So, we think great savings can come from this. We also think that if we do something about malpractice, and we have set forth in the report about six approaches to do something about malpractice, savings will result. We have taken those from States that have already tried these approaches. It is beginning to work in some of these States, and we need to look at those to see if they should be incorporated Nationwide.

Some of those have already been adopted in as many as 35 States, so we have some experience that the Committee could look at and begin to do something about that. It won't be easy because you have got the trial lawyers that will give you a rough time, but it is going to have to be addressed. We think that needs really to be done.

So, let me conclude by just saying that we do believe we need Universal Access. We need to do something on costs, and we think we have presented approaches here. We must do something on quality.

Incidentally, you'll be interested to know that the American Medical Association does not disagree with that, and has already been negotiating with the RAND Corporation to do research on quality. So, the profession has recognized it.

Let me say that what I am encouraged about as we begin this national debate, and certainly this Committee is contributing to that in a significant way with your hearings, is the fact that more and more groups are saying it must be a systemic approach. Systemic. It can't be just the patchwork again.

You've got people like AARP, who have already made the statement on it. You're getting industry constantly. Of course, labor has already taken that approach. I am really encouraged by the fact that the idea of a systemic approach is growing in the Nation. That will lay the foundation for something to be done. As you know, the

Congress is having this question looked at by the Pepper Commission, the members of both bodies, and Deborah Steelman—one of your witnesses here—will be looking at the matter in her quadrennial commission on Medicare.

Many things are coming together, so the timeliness, I think, Mr. Chairman, of your hearing in the Committee here, is excellent, and certainly will make a significant contribution to the solution of this problem. Thank you.

[The prepared statement and material subsequently received from Mr. Rogers follows:]

Testimony of the

HONORABLE PAUL G. ROGERS

**Co-chairman, National Leadership Commission
on Health Care**

Presented before the

HOUSE SELECT COMMITTEE ON AGING

November 9, 1989

Paul G. Rogers, an attorney with Hogan & Hartson, was a member of Congress from Florida from 1955 to 1979 and Chairman of the Subcommittee on Health and the Environment from 1971 to 1979.

I would like to address four main issues: the need for comprehensive reform of the health care system; the ways in which the plan of the National Leadership Commission on Health Care addresses the three major problems facing the health care system in a comprehensive proposal; the basic elements that should be in any package that the Congress considers and, finally, the major political issues involved in comprehensive reform.

The private, bipartisan National Leadership Commission on Health Care came together three years ago to examine and propose a solution to the problems of access, cost, and quality in health care. The Commission soon found that these were interwoven issues that could not be separated and targetted for change, one without the other. Limited access, soaring costs, and uncertain quality interact with the malpractice crisis to form a tightly woven web. We need to take the best features of this intricate design and weave them into a renewed system of health care. Then we can afford to provide universal access and long-term care, because the system will be of uniformly high quality, with controlled costs, and without the burden of the malpractice insurance crisis.

The Commission first examined each of these problems separately. As we did so, the analysis of each problem revealed the connections to the other problems. When we looked at the nature of the problems with access to the system for the millions of Americans without health insurance, we found that the high cost of insurance was a problem, both for some employers and for workers with low incomes. So access and cost were closely connected. When we turned our attention to costs, we found that costs were soaring in health care, without any apparent limits to how high they could go. We found that cost shifting from the public to the private sector had resulted from past government efforts to control costs and had prevented these efforts from being fully effective. Thus it became clear that the public and private sectors must join in finding a solution to these problems.

When the Commission looked at problems in the quality of care, we found that there were basic uncertainties about the appropriateness and effectiveness of many of the major procedures we perform. In addition, there are wide regional variations in the numbers of tests and procedures and even variations within major cities, between hospitals. A recent study found 11-fold variations between neighboring communities in Vermont in the number of tonsillectomies performed. Thus there is a need for a national solution to the problems in quality.

The Commission also heard strong testimony that some of the problems in quality could be traced to defensive medicine, to the need for providers to do as much as possible, without sole regard for appropriateness and effectiveness, because of the concern over possible malpractice suits. Thus the quality issue is tied to the malpractice insurance crisis. The soaring number of tests and procedures ordered has led to greatly increased costs in health care. In fact this single element, intensity of services, is one of the most significant and fastest growing contributors to the cost of care.

When the Commission turned its attention to the malpractice crisis, the Commission found that the current system of malpractice litigation impedes the delivery of economical, high quality care. It is clear that malpractice litigation has driven up the cost of medical care overall, and for some specialties, at a dramatic rate. Providers who can obtain malpractice insurance must pass on its rising cost to patients or third-party payers through increased fees. For some providers in particular specialties or jurisdictions, malpractice insurance is simply not available at an affordable rate. Therefore, the malpractice crisis can affect access as well as costs, because we now witness physicians refusing to perform risky procedures, changing location or specialties, or retiring early from medical practice. The result has been loss of access to critical forms of medical care -- such as obstetrics and complex surgical procedures -- in many areas.

In fact, it is striking how the issues in the malpractice arena affect every facet of our health care policy. The range of issues involved in malpractice include quality of care concerns, because the fear of malpractice suits encourages defensive medicine, in which providers perform additional procedures, especially diagnostic ones, principally to protect themselves against law suits. Such procedures increase both the cost of care and sometimes health risks to patients. The rising rate of Cesarian section deliveries and excessive reliance on fetal monitoring are illustrations of this trend.

The damage done to American health care as a result of these interwoven problems is serious and sustained. The basic relationship in the delivery of care has always been the doctor-patient relationship. That relationship has been corroded by the problems we have enumerated. Too often, the specter of malpractice suits threatens the mutual confidence and trust essential to the healing process at work in the relationship between patient and physician or nurse. Widespread media coverage of the problems in the access to care has probably played a part in the diminished public approval of the health care system. Finally, the increased cost-sharing by employers with employees has made the public aware, often for the first time, of the rapid run-up in costs for health care.

The result is that a system which has been built over the years on the trust between doctor and patient has been severely damaged by the interrelated problems of access, cost, quality, and malpractice. Before there is an irreparable break in the bond of trust, we must strengthen the entire health care system and repair all the links that tie the system together. To do that requires, I believe, a comprehensive approach that leads to a plan to reform the four connected parts of the health care system.

The framework for change, the Commission believed, should be a shared responsibility, between individuals and their employers on the one hand and between government and the private sector on the other. A $600 billion system, health care is the third largest sector of the economy. Everyone shares in its problems and should share in devising solutions to those problems. The Commission based its plan on several basic precepts. One is that individuals should take greater responsibility for obtaining, paying for, and understanding their own helath care. Under the Commission's plan, therfore, individuals have the primary responsibility for having health insurance, either through their employers, their own purchase, or the Universal Access (UNAC) Plan proposed by the Commission. Since most employers now offer their employees private health insurance, the basic American system of providing health insurance would remain in place.

Change would come in the area of providing health insurance to those with inadequate coverage. This would be done through the UNAC program. Moneys for this solid, basic benefits program would be collected nationally, thereby spreading the cost across the vast majority of Americans who can afford to pay a small amount toward basic health care for the uninsured. Individuals earning over 150 percent of the federal poverty level would pay 0.6 prcent of income up to the social security taxable maximum to support this program. It would be administered by state agencies whose structure would include representatives of payers, providers, and patients. UNAC would negotiate rates annually with providers, which would bring cost control into the UNAC system, since these rates would be set for perhaps one in four Americans, 60 to 70 million people. The self-employed and private employers could voluntarily join in adopting UNAC-bargained rates at the beginning of a rate-setting period.

Under our plan, employers would be encouraged to continue and extend the provision of health insurance to their employees. The plan provides an incentive for all employers to offer insurance, by setting a rate of 9 percent of social security wages which would be paid into the UNAC program if coverage was not provided. Employees in those firms which do not provide coverage would pay 2 percent of wages to participate in UNAC. The Commission envisioned a UNAC system which would provide good basic benefits to the participants, while allowing state variations above the basic package. They anticipated coverage of basic medical and surgical benefits as well as cost-effective preventive services, such as prenatal care.

The health care premium and fees for the UNAC system would also provide funding for another key element to this system, the National Quality Improvement Initiative. This initiative will result in higher quality care, so that universal access will be provided to a more cost-effective system and one that provides more appropriate and effective care. Under the initiative, outcomes research will be conducted on all major procedures and national guidelines will be developed by physicians with funds from the UNAC premium dispersed by the federal government. These guidelines, which will show when major procedures are indicated, are unnecessary, or are equivocal, will be available to patients and payers as well as providers of care. Better educated consumers will help both to improve the health care system and hold costs down. The availability of this information to the UNAC agencies would allow them to make the most informed buying decisions.

The program would be phased in over several years, so that the gains from quality improvement would be made as increased access is provided. While the UNAC plan is being set up, for example, the quality initiative will be phased in, providing for gradually increased research. Under the initiative, for example, we could concentrate first on those procedures on which we spend the most money, since the potential is there for major savings. The Commission made a conservative estimate that reducing the amount of inappropriate care would save $84 billion over four years. There is potential for even higher savings once the system is fully operational, since the 70 major procedures we do account for about half of our national health expenditures.

Because this system is comprehensive, it would limit the shifting of problems that has occurred in the past. And each effort, such as the quality initiative, would benefit both the public and private sectors. The shifting of costs from the public to private sectors would be minimized. There are built-in cost control elements in the plan and other cost control measures which the Commission hopes would expand, such as private purchasing of care through arrangements such as preferred provider organizations.

These efforts, the Commission believed, should be combined with a plan to expand current fragmented malpractice reform efforts. This would bring an end to the need felt by too many physicians and hospitals to practice defensive medicine and conduct tests and procedures beyond those that are necessary. The malpractice reform package includes strict criteria for expert witnesses, limits on contingency fees and punitive damages, accelerated trial schedules for malpractice cases, and increased use of arbitration and mediation. The Commission hoped that more states would adopt these measures, but the group also felt that, if this did not happen as the new system was put into effect, federal preemption should be considered.

Since the Commission released its report in January, the Physician Payment Review Commission (PHYSPRC) sent its 1989 report to Congress calling for physician payment reform. Our Commission called for consideration of the physician payment reform that was about to be issued and recommended consideration of the epxenditure target concept mentioned in the PHYSPRC report. Clearly, both proposals, if extended to the private as well as the public sector, would help hold down overall increases in the cost of health care.

I believe, as a result of the consensus achieved by the diverse group of people in our Commission, that it is possible to achieve a comprehensive new plan for health care while, at the same time, preserving the best of the American system of pluralism and freedom of choice. It is possible, in other words, to build on the finest features of the American system a strengthened national health care system which will develop a strong public-private partnership to provide universal access to the basic benefits of health care while improving the quality of that care and taking actions to include cost control elements in each aspect of the plan.

We are encouraged that other groups are also calling for comprehensive health care reform. For example, the American Association of Retired Persons, the Association of Academic Health Centers, the board of the American Academy of Family Physicians, and the president of the National Rural Health Association have issued statements in support of this approach. Presidents Carter and Ford endorse our plan. A growing number of business and labor leaders, such as the chairman of the National Association of Manufacturers, Richard Heckert, understand the need for a comprehensive approach to changing the health care system. I sense a growing coalition among diverse sectors across the country in support of comprehensive health care reform.

The growing interest in the Congress, as exemplified by this hearing and the others that have been held over the past year, demonstrate the response to this groundswell of interest. The poll by Louis Harris and Associates released early this year emphasizes the major change that has taken place in the public's attitudes toward the health care system. It represents an extraordinary reversal in opinion that now finds 89 percent of the people surveyed are dissatisfied with the health care system. When Harris testified earlier this year about his findings, he spoke of how reluctant Americans are to criticize their own system. He said that this made him even more concerned about the results of this poll. It seems to me that we, as politicians, can ignore the polls for awhile, but that if these findings hold up in subsequent polls, we cannot ignore them for very long. Then the critical elements will be in place for comprehensive health care change. All the major sectors of our society will be demanding basic improvements in our health care system, and I believe the consensus position arrived at by the National Leadership Commission will help point the way.

December 22, 1989

Response of the Honorable Paul G. Rogers to Questions Posed by the House Select Committee on Aging, Edward R. Roybal, Chairman.

1. Question: On the issue of financing, please review the financing plan for my USHealth legislation and give me your opinions on that financing package. Also, please detail what financing sources you believe to be the best choices for financing health and long term care in this country and approximately what portions of this care should be financed by each source.

Answer: Clearly, the issue of how to finance universal access and long term care in an era of large budget deficits is the toughest challenge facing policy-makers. In the course of its deliberations, the Commission looked at both the methods used by other countries and several possibilities for the U.S. The Commission declared its preference for using general revenues as the funding source. However, the size of the deficit caused the Commissioners to decide they should choose another funding source at this time.

They liked the concept of an identifiable funding mechanism and one that was similar to the payment system in the private sector. Therefore, the Commission chose a national health insurance premium to be paid by all Americans earning over 150 percent of the federal poverty level. This funding source would be understandable to the American people, since it is similar to the private insurance premium familiar to so many. At the same time, it is similar to the user fee concept which was employed effectively to build the interstate transportation system and to fund the public education system. Since the release of the Commission's report, one of our members, Alice Rivlin of the Brookings Institution, has written a persuasive op-ed piece on the possible use of a value-added tax (VAT) (see enclosed) for expanded health benefits.

Despite the difficulty of coming to agreement on any additional form of financing, I think it would be more difficult if we turned to multiple sources of funding, as the USHealth plans suggests, because more interests are immediately affected. A number of them could be expected to oppose even the small incremental increases called for in each area under this plan.

2. Question: On basic access, do you agree that comprehensive reform needs to ensure insurance coverage to all Americans, especially poor and near poor Americans whether they are working or not?

Answer: Our Commission clearly and unanimously agreed that comprehensive health care reform should encompass universal coverage for all Americans to basic medical and surgical care. The Commission began by examining the nature of health care, determining that health care, while not a legal right, was definitely a basic social good. The Commission found that the basic health of all our people would contribute to the health of our society, a notion that led to the title of our final report, "For the Health of a Nation."

The Commission was deeply disturbed at the lack of such cost-effective preventive services as prenatal care for millions of Americans, an absence which probably contributes in an important way to the nation's high infant mortality rate. The Commission called for such measures to be included in any basic health care plan for the currently uninsured and underinsured.

3. Question: On quality, do you agree that publicly-accountable quality assurance, like Medicare's peer review organizations and federal and state nursing home and hospital regulation, should apply to all patients and providers regardless of who pays?

Answer: I would certainly agree that quality assurance programs should be widely available in both the private and public sectors. The Commission went even further, however, in its call for quality improvement. Quality was one of the three areas on which the Commission focused its work, the other two being cost and access. We examined two aspects of the uncertainties in quality in the American health care system, the issue of an absence of quality control procedures and the need for improvements in the appropriateness, effectiveness, and quality of care being provided.

The Commission found an absence of widespread quality control procedures throughout the health care system. We found that quality controls, such as those in American industry, are largely absent. Experts believe that if industry's quality control measures were applied to the service sector of the economy, major improvements in efficiency, and therefore major cost savings, could be made. The Commission found it important to reduce the amount of errors and rework prevalent in the health care system by adopting such techniques on a widespread basis.

In response to the wide regional variations and uncertainties in the quality, appropriateness, and effectiveness of much of the care being delivered, the Commission also called for a major National Quality Improvement Initiative. This Initiative provides for a major, continuing investment in technology assessment and outcomes research on the major procedures we perform, in order to properly evaluate the need for conducting these procedures. The result of these ongoing studies would be national practice guidelines which would be provided to physicians and other providers, patients, and payers alike.

The guidelines would be used to help educate all the participants to the indications for a given procedure and therefore to eliminate as much unnecessary care as possible. Studies conducted at the RAND Corporation by panels of physicians looking at some of the most frequently performed procedures, have shown that between 14 and 32 percent of these procedures were unnecessary and inappropriate. This Initiative addresses the need to eliminate as much unnecessary care as possible, both to improve the quality of health care in this country and to lower its cost. It is clear that this Initiative would have implications for alleviating the malpractice insurance crisis as well.

4. Question: On services, do you agree that both long term care and acute medical care need to be covered services?

Answer: The Commission addressed the need for basic medical and surgical services. It found that long term care included a range of services, some health-related and others not. Because of this mix of needs and services and because some members of the Commission were working on their own proposals to respond to the need for long term care services, the Commission did not include long term care in its plan. However, the Commission did state that a long term care plan which integrates public and private sector support for the range of services called for by this complex set of needs would fit with the Commission's reform plan for the rest of the health care system.

5. Question: On costs, do you generally agree that health costs need to be limited to about 12 percent of GNP, payments should be prospectively set and indexed, and patient out-of-pocket liability limited?

Answer: The Commission did not address the appropriate percent of GNP at which health care expenditures might be pegged. That is an interesting concept. The Commission's concerns revolved around both the high level of expenditures in this country in general over the past twenty years and the rapid rate of increase in those costs. In order to hold down expenditures, the Commissioners felt that cost control measures should be incorporated into the new health care system. Your plan suggests one way to do that.

The Commission's plan calls for the Universal Access (UNAC) program to provide basic health care benefits to all Americans who would otherwise be uninsured. At the same time, the plan called for built-in cost control through the negotiation process at the state level, where the UNAC plan administrators would negotiate with groups of providers for the care to be delivered to UNAC participants. These state programs would have the weight of numbers on their side, since as many as 60 to 70 million Americans would probably be UNAC participants.

A second and particularly important aspect of built-in cost control in our proposed system is the National Quality Improvement Initiative. The ongoing research and resulting guidelines for all major procedures should cut back the amount of unnecessary procedures and cut billions of dollars out of the system. By a conservative estimate, expenditures would fall at least $84 billion over four years with the development of guidelines on some of the most popular procedures.

More general cost control measures endorsed by the Commission included such now-standard measures as encouraging business to look at more cost-effective purchasing, including the use of preferred provider organizations. The Physician Payment Review Commission issued its report after ours was released, but the Commission was aware of and in general support of the Hsaio study which formed the backbone of that Commission's proposal to Congress.

The Commission found that patients who never share in the payment of premiums or health care outlays do not fully appreciate the value of their health care coverage. The Commission therefore urged that individuals assume greater responsibility for their own health care in several ways, by contributing toward paying for their health insurance whenever possible, through co-payments, and through participating in paying for the UNAC program which will benefit all Americans, through its quality improvements and cost control features, in addition to providing universal access to those without health insurance coverage.

6. Question: Isn't your approach somewhat similar to that of Massachusetts? What is different and what can we learn from their early experiences?

Answer: The Commission's plan is fundamentally different from that of Massachusetts. What sets our plan apart most clearly is that it is a systemic approach. The Commission's comprehensive plan includes the National Quality Improvement Initiative, built-in cost control elements, and a malpractice reform package, none of which are part of the Massachusetts plan. The Universal Access plan itself is different, placing the responsibility for having health insurance on the individual, not the employer.

It is the individual who must obtain health insurance coverage in one of three ways under the Commission's proposal: individual purchase, employer coverage, or the UNAC plan. The Commission's plan also includes a significant incentive to employers to offer insurance, by levying a fee of about 9% of earnings up to the social security maximum under the UNAC plan unless they offer insurance to all their workers. Our plan also offers a different provision for part-time workers, covering them all and paying for them by paying the insurance premium based on number of hours worked. Therefore, an employer with a part-time worker employed for ten hours a week would pay one-quarter of the regular premium for that person. That way, no part-time worker goes without health care coverage, an important provision which is different from the other plans.

The Massachusetts experience illustrates once again, I believe, that the system of providing health care in this country is not improved just by providing universal access to care, important as that coverage is to many Americans. Many participants in the system in Massachusetts remain unhappy with the current plan. This confirms our view that malpractice reform, quality improvements, and cost control must go hand in hand with universal access if we are truly to achieve basic improvements in the health care system.

7. Question: Given the importance of quality assurance and cost containment in your proposal, how do we ensure that quality assurance reaches everyone and is not limited to publicly-sponsored programs?

Answer: The key here is a careful integration of the public and private sectors. We acknowledged the importance of this issue in the subtitle of our report, by calling our proposal "A Shared Responsibility." By that sharing we meant the public and private sectors as well as the individual and his or her employer. Your question and our emphasis are direct recognition that we have a national system with problems and prospects that affect every one of us. We must all be part of the development of a solution, as we have all been part of the development of the problems.

In part, the integration we all seek will be handled at the state level by the agencies that administer the UNAC program, since we called for those agencies to include private sector representatives as well as public administrators. In addition, we left open the possibility that businesses could join the UNAC plan at the beginning of a rate-setting period; this is another form of integration. The National Quality Improvement Initiative will also bring results for the private as well as the public sector, since the guidelines will be available for everyone in the country to use. Malpractice reform too will benefit all participants in the system and remove some of the underlying animosities which create unpleasantness.

The key here is that unless all parts of the health care system undergo related change, there will be shifting between the various sectors and a need for continual, incremental change which will not achieve the goals we all intend. Systemic reform is the only effective way to achieve major change in the health care system.

Mr. Roybal. Thank you, Mr. Rogers. The Chair now recognizes Mr. Fraser.

STATEMENT OF DOUGLAS A. FRASER, CHAIRMAN, COMMITTEE FOR NATIONAL HEALTH INSURANCE, WASHINGTON, DC

Mr. Fraser. Thank you, Mr. Chairman. I wish to thank you for this opportunity to appear before the Committee and members of the Committee.

I'd like permission, Mr. Chairman, to have accepted into the record my complete statement, and I will try to keep it in the time constraints.

Mr. Roybal. I thank you, and please proceed. Your statement will be included in the record in its entirety.

Mr. Fraser. Thank you very much. The health delivery system in the United States is in disarray. It is in absolute shambles. The American people's view of the health delivery system is dismal. There is a Lou Harris poll recently conducted that tells us that 89 percent of the American people are dissatisfied with the health delivery system that exists today.

You're all familiar with the figures, some of which are recited by Congressman Rogers. We're spending over 11 percent of GNP. That is probably going to amount of $600 billion this year. We start thinking about what the costs of a new approach to national health care—you keep in mind not doing anything, meaning this wild escalation of health care—costs tens of billions of dollars a year.

There are a couple of new figures that I'd like to share with the Committee that are relatively new. If you look at the last 12 months ending at the end—the last day of September, the health care costs rose three times those of wages and salary, and also rose three times the increase in the CPI.

In the auto industry, we're looking at some figures, and the cost to the auto companies now for health care is just below $5,000 per active worker. This does not include our dental and vision care programs.

Depending upon the volume of production, you can figure that health care costs is costing about $700 a car. That is not only a horrible burden to impose upon the consumers, the people that buy automobiles, but also it greatly impedes our international competitive position when every other Nation with which we compete in the automobile industry, has health care costs just a fraction of ours.

In the labor relations front, many, many strikes result almost exclusively over health care costs. Recent strikes in the communication industry—the basic core of that strike was health care costs. In the last three negotiations in which I participated in in the auto industry, the last thing we were able to settle was the health care costs.

Things have changed since we last had a national discussion of health care. The change has come about because so many employers in America have now joined forces with those who want to examine a new approach. The Chrysler Corporation, through its Chairman, Lee Iacoca, has made many statements now advocating a national solution to this problem. The Ford Motor Company has done likewise.

Their motives are different from mine. Their motives are that they can't control the situation anymore, and the costs are out of hand, and they are beginning to worry about their competitive position.

I joined them in their approach because I have always believed that every man, woman, and child in the United States should have health care—not as a matter of privilege, but as a matter of right.

I agree with the Chairman. I agree with Congressman Rogers that a patchwork approach simply will not work. We have done enough of that. Oftentimes, I think every time we do something, we exacerbate the situation.

I am Chairman of a group called the Committee for National Health Insurance. We have been in existence for 23 years. Over the years, we have presented a variety of plans. About 5 years ago, we decided to look to a new approach, and we formed what we call the Expert Committee, headed by Professor Rashi Fein, of the Harvard Medical School.

We designed a new plan, the principles of which I propose to summarize. One of the basic departures from the past is that we want to give the States a greater role in the system. It is the States who would administer the cost controls and quality assurance.

So, the Health Security Partnership Plan, which our Committee advocates, is based upon nine principles—full access to all Americans, benefit comprehensive enough to provide equal medical care for all, meaningful cost containment measures built into the plan (these include advance approval of national and State budgets with ceilings on national expenditures set by growth in the GNP), prospective budgets for hospital and laboratory services, controls on physician payments within budgets determined by relative value schedules, and annual caps or expenditure targets for these expenditures.

The first phase of the program for long term care is included as a benefit. It is regrettably limited in scope. Provisions are made for its expansion as the program develops, but we believe a start, no matter how modest, is necessary in any national health plan.

Special provisions to maintain and strengthen the quality of health services through technological assessments of newly evolving procedures, evaluation of outcomes of clinical treatments, and the distribution of these findings in the form of treatment guidelines to the appropriate health professionals.

Simplified administration designed to eliminate waste duplication and inefficiency—our estimates indicate that upwards to $20 billion a year could be saved.

Provisions for the beginning of restructuring the organization and delivery process—consumer participation could be assured in the policy development with consumer recourse to organized grievance procedures.

Finally, sufficient relationship to present programs to ensure evolution into the new plan and continued evolution in the future. Under this program, Medicaid would be integrated into the Health Security Partnership. Medicare would continue as a separate and parallel program, eventually being incorporated into the Health Security Partnership.

In my statement, it outlines the method by which we propose that this program be financed. I note with pleasure the United States Health Program, H.R. 2980, which was introduced by the Chairman.

I suppose the basic difference between your proposal, Mr. Chairman, and our new proposal, is ours is more State oriented. Other comments about H.R. 2980 are contained in our complete statement.

Hopefully, the Health Security Partnership Plan will make a contribution to what, I hope, will become a national debate. This is hardly a novel, radical idea. Every single democracy in the world except the United States has a national plan.

We spent a great deal of time looking at the Canadian model, which seems enormously successful, in terms of servicing—all of the people having access and universal coverage. The Canadian people express enormous satisfaction with their program. Ours adopts many of its key features.

So, thank you, again, Mr. Chairman. Hopefully, as you suggest, we can have a national debate on the various plans.

[The prepared statement along with material subsequently received from Mr. Fraser follows:]

TESTIMONY IN BEHALF OF
THE HEALTH SECURITY PARTNERSHIP

Presented by

DOUGLAS A. FRASER

Chairman, Committee for National Health Insurance

Former President, United Automobile Workers

Prepared for

THE SELECT COMMITTEE ON AGING,

HOUSE OF REPRESENTATIVES

November 9, 1989

Washington, DC

Mr. Chairman, and Members of the Committee, I am pleased to appear before you this morning in behalf of a coalition of leaders of major labor unions as part of an American cross-section representing women, youth, senior citizens, education, religious and farm organizations.

The evidence, we believe, is overwhelming that the system and its programs are in disarray. This is evident in recent polls that indicate 90% of all Americans think health care needs fundamental change. They reject the propaganda which attempts to tell them we have the best health care in the world. On a personal basis, 45% of them are not happy about their last experience with a doctor.

And the costs are unbelievable. In the 12 months ending this past September, health insurance costs increased 4 times as rapidly as wages and salaries, and 4 times as rapidly as the Consumer Price Index in the same period. Put another way, in the state of Michigan, the average health insurance premium for an auto worker family is currently just under $5000 per year*. Think for yourselves what it must mean for the average constituent in your district who doesn't have good insurance to have to pay this sum to protect his family.

It goes a long way toward explaining why major employers have taken a complete about-face in attitudes and are now calling for a national health program. They see this as imperative if America's competitive position in world markets is not to be further eroded.

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* Not including cost of prepaid dental care and vision care.

The recent upsurges in strikes in the telephone industry, in mining, and in auto supply -- caused primarily by employer insistence that much larger shares of the cost of health insurance be transferred from them to their workers -- are causing increasing industrial strife. This tension will not be decreasing.

And, unlike almost every other industrialized nation in the world, more than 52 million Americans are without the protection of health insurance or have so little that it would not cover the payments for medical care for moderate illnesses.

The erosion of the protection of access to health care for America's children is a less dramatic, but perhaps more important, aspect of what's happening in health care today. Members of Congress and others have pointed with pride to the fact that between 1984 and 1987, 600,000 children have been brought under Medicaid benefits. Less well known are the data that indicate that, in the same period, 1,200,000 children lost insurance coverage. This is particularly disturbing when one reads the report of a recent study in the New England Journal of Medicine: "Babies whose parents lack health insurance are 30% more likely to die at birth, or be born seriously ill, than insured babies."

Over the last 20 years, our nation has tried a series of piecemeal, patchwork, fragmented approaches to solving the problems of cost and quality in health care. They have all failed. As Clark Kerr, Vice President and Manager of Corporate Programs for the Bank of America, said: "If I were rational, I'd be totally pessimistic, because everything we've tried has fallen flat on its face."

About 5 years ago, our committee recognized the crisis which was developing in health care, and appointed an expert committee, led by Professor Rashi Fein of the Harvard Medical School, for the purpose of studying the problem and arriving at a comprehensive, rather than patchwork, answer to how to make decent health care available to all. This has taken the form of the **Health Security Partnership** plan. The plan is built on a partnership between the state and federal levels of government.

This recent departure from earlier designs, which looked to the federal government to enroll, finance and administer the programs, in contrast, looks to the states to enroll the population which would be covered and to administer the cost control and quality assurance efforts for the program that each of them would be operating.

Furthermore, our studies have convinced us that health care is a local service and that the new complex of personal health services now functioning requires local adaptation in ways that cannot be mandated from Washington.

Nevertheless, in the new proposed partnership, we recognize that it is essential that there be ground work and rules set by the federal government to mandate a comprehensive list of benefits that all states have to provide, and to prevent competition among the states around benefit packages. States, too, can and should take responsibility to develop effective cost control and quality assurance programs.

The plan is based upon 9 principles:

1. Full access to all Americans;
2. Benefits comprehensive enough to provide equal medical care to all;

3. Meaningful cost containment measures built into the plan. These include advance approval of national and state budgets with ceilings on national expenditures set by growth in the Gross National Product, prospective budgets for hospitals and laboratory services, controls on physician payments within budgets determined by relative value schedules, and annual caps or expenditure targets for these expenditures;

4. The first phase of a program for long-term care is included as a benefit. It is regrettably limited in scope. Provisions are made for its expansion as the program develops, but we believe a start, no matter how modest, is necessary in any national health plan.

5. Special provisions to maintain and strengthen the quality of health services through technological assessments of newly evolving procedures, evaluation of outcomes of clinical treatments, and the distribution of these findings in the form of treatment guidelines to the appropriate health professionals;

6. Simplified administration designed to eliminate waste, duplication and inefficiency. Our estimates indicate that upwards of $20 billion a year could be saved;

7. Provisions for the beginning of restructuring the organization and delivery process;

8. Consumer participation to be assured in policy development, with consumer recourse to organized grievance procedures;

9. Sufficient relationship to present programs to insure evolution into new plans and continued evolution in the future.

Under this program, Medicaid would be integrated into the Health Security Partnership. Medicare would continue as a separate and parallel program, eventually to be incorporated into the Health Security Partnership.

The private health insurance industry would participate fully in the new partnership through state governments. The insurance industry would be required to community rate all employers, thus reducing the incentives to discriminate against those who are elderly, handicapped, or otherwise requiring full services. Balance billing would be mandated and Medicare assignment required.

The costs of bringing the tens of millions of Americans now outside our health care system into the mainstream are substantial, but not prohibitive. Taking into account extensive savings realizable from the institution of realistic cost savings, our experts estimate that by the third year of the new **Health Security Program,** we should be expending about 5 % more in total health expenditures than the government estimates would be required to continue the present unchecked, disorganized system. Of the total sum of $31 billion a year in new money required, about one-third would come from the federal government in the form of expanding the Medicare payroll tax to cover all income levels. In addition, the federal excise tax on cigarettes would be raised by 32 cents and indexed to the per capita GNP. Employers would also pay a tax based on a percentage of employee compensation. The states would pay the second third of the required increase in expenditures with funds they might raise by any means they consider appropriate, so long as it is within the limits of the biennial nationally approved **Health Security Partnership** budget. The final third would come from increased insurance industry premiums limited by state budgets.

Mr. Chairman, I note with pleasure the "USHealth" program, HR 2980, recently introduced by you. By my count, this represents the fifth serious program which addresses the national health crisis we face. I applaud this, for it increases the possibility that a serious comprehensive approach will be adopted, rather than still another piecemeal, fragmented solution, each and all of which have failed in recent years. The efforts in your bill to provide comprehensive benefits in a cost and quality constrained environment are in several ways similar to those in the **Health Security Partnership**. Yours, however, is primarily a national program while ours, based on the experience of recent years, is more oriented to state and local initiatives. I believe, however, that the financing of USHealth needs considerably further examination, for it increases by a considerable amount payments required of workers and their families through the exclusion from income of employer health insurance contributions and a requirement of new income surtaxes.

The **Health Security Partnership** represents a new advance in national health care programming. It assures immediate cost containment and improved restraint of costs in subsequent years. It makes possible achieving improved quality of care and assures consumer participation in every level of policy and program development. And, above all, it assures equity and access to health services across the nation.

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THOMAS R. DONAHUE, Secretary-Treasurer
MRS. ALBERT D. LASKER, Vice Chairman
VERNON E. JORDAN, JR., Vice Chairman
MELVIN A. GLASSER, Director

November 29, 1989

Honorable Edward R. Roybal
Chairman
Select Committee on Aging
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Roybal:

I appreciated the opportunity to appear before the Select Committee on Aging to testify at the November 9th hearing. As you well know, the proposed solutions to the nation's health care problems need to be discussed side by side so that appropriate comparisons might be made.

It seems to me that the financing package for your USHealth legislation needs substantially further examination before sound choices can be made. For example, our own review would indicate that at this point it is unrealistic to expect to see passed a measure which would finance health and long-term care concurrently. You recognize, too, the costs are not comparable. Private long-term care insurance coverage is only in its infancy. Responsible studies indicate that in the next several decades, such insurance is likely to cover perhaps 12-15% of the needs of the elderly and disabled. The balance would have to come from individual payments or public programs.

On the other hand, the costs of bringing 50 million people now essentially outside the health system into it, even with the drastic cost containment reforms we propose, will add major new tax burdens.

We have evaluated for some years now the relationship between long-term care benefits and those involved in basic system reform. It is our considered judgment that system reform across the board must come first. Along with this should be a gradual phasing-in of long-term care benefits. Accordingly, it seems to us unrealistic to expect responsible judgments on "approximately what portions of this long-term care benefit should be financedby public funds", along with basic system reform for all.

It seems to me, too, that USHealth will increase by a considerable amount payments required by workers and their families through the exclusion from income of tax exemptions for employer health insurance contributions and a requirement of undetermined new income surtaxes on workers . As you know, in the past year increases in costs of health insuranced were three times as great as increases in worker income. I would question the wisdom of making this situation worse.

This leads me to question the appropriateness of an arbitrary limit, like 12% of GNP, for financing. While I would agree that payments should be prospectively set and indexed, our objective is to reduce patient out-of-pocket liability. We see no good reason to assume that access to health services should be any less available than access to elementary and secondary education.

The labor movement took the lead in the 1960's in the effort to promote health maintenance organizations. You will, of course, recall that for years major employers resisted these changes until it seemed clear that they were both quite effective and saved a great deal of money. This paved the way for what is now called "managed care".

As a start, I would hope your Committee and others in the Congress would hold a series of hearings in 1990 on bringing about comprehensive system reform in the delivery of health services and providing for far more consumer participation in policy formulation and in an organized patient grievance system.

We have departed from earlier decisions for primarily federal programs in health care because of our strong conviction that local services need to be flexible, responsive in differing ways to the complexity of services required where people live, and sensitive to unique problems which may not be nationwide. The current crisis with epidemic AIDS is a good illustration. This is primarily a problem of the East and West coasts. The dimensions of the problem and the approaches required to meet them are strikingly different in much of the country where AIDS is not a significant health issue. New Jersey and Missouri both have big city health problems, but they are dramatically different in the morbidity and mortality of AIDS.

Further, in recent years the states have demonstrated markedly improved competence in dealing with health programs. This provides added strength to the national-state approach. I affirm, however, that strong national participation continues to be important.

On basic access, you raise certain questions which go to the heart of the issues. I believe my testimony made clear that my conviction is strong that equal access should be assured to all Americans, whether they are working or not. I have reservations, however, about the emphasis on the "especially poor and near poor". This kind of thinking has led us to the notions which produced Medicaid and welfare-related health plans. Recent studies by the Institute of Medicine have illustrated that special programs for the poor, like those in maternal and child health, have not worked well and are far less productive than they mightbe. They also encourage the notion among many that two standards of health services are not particularly bad, especially if those presently underserved get "something" out of the system.

On quality, we of course agree that public accountability needs to be enhanced. We also believe, however, that a great deal more is known today about standards for quality care, improvement in delivery methods, clinical goals for treatment, etc., than we did half-a-dozen years ago. Accordingly, we would hope that these new additions to knowledge about how to improve quality would be reflected in any of the proposals for system change which are being considered.

Sincerely,

Douglas A. Fraser

Douglas A. Fraser
Chairman

Mr. ROYBAL. Thank you, Mr. Fraser. The Chair is now pleased to recognize our neighbor to the north, Canada. Our third witness is Mr. Graham W.S. Scott, Q.C., who served as the Deputy Minister of Health for the Province of Ontario.

Currently, he is a partner with a firm in Toronto, and often serves as intermediary between the Ontario Medical Association and the Province of Ontario.

We are pleased to welcome you this morning, Mr. Scott, and I ask you to proceed in any manner that you may desire.

STATEMENT OF GRAHAM W.S. SCOTT, Q.C., PARTNER, McMILLAN, BINCH, BARRISTERS & SOLICITORS, TORONTO, ONTARIO, CANADA

Mr. SCOTT. Thank you, Mr. Chairman, members of the Committee. It is a privilege to have the opportunity to appear before you to discuss the health care system in Canada.

I should point out at the outset that my experience in the Canadian health care system arises from system and policy management. I am neither a doctor, nor a health economist—something which has been pointed out to me on many occasions, is either an advantage or a disadvantage, depending on who makes the observation. My experience arises from 3 years in the early 1980's as Deputy Minister of Health in Ontario.

In context, Ontario is Canada's largest political jurisdiction with 9.5 million people. Its Medicare program is probably the most sophisticated in Canada. When I departed in 1984, the direct health expenditures in the Health Department of Ontario were $8 billion. For the 1990 estimates, we'll probably exceed $13 billion.

Currently, I serve as the independent Chairman of the Task Force on the Use and Provision of Medical Services. The Task Force is a joint endeavor, Mr. Chairman, as you pointed out, of the Ontario Medical Association and the Ontario Government, focused on finding more efficient ways to deliver health care.

Permit me a few words on the Canadian health care system which Canadians refer to as Medicare. The Medicare program developed over a period between 1947 and 1972. By 1961, all Canadians had government-financed hospital care. By 1972, they had both government-financed hospital and medical care.

Health administration under our constitutional arrangements rest with provincial authorities. The Federal Government has a substantial role to play through its block funding mechanism. The block funding element provides the Federal Government with the leave reached to establish broad policy parameters which guide the system. Of the total government share of health care spending, just over 40 percent comes from the Federal level, with just under 60 percent coming from the provinces.

As politicians, you are accustomed to polls and public opinion. It is probably fair to say that ongoing government programs seldom receive widespread public support or freedom from substantial criticism. For some reason that I don't fully understand, Canadian Medicare is a clear exception to this rule. Its popularity rating reveal jealousy in the political arena. Support of the model has always been above 90 percent, and approval of day-to-day management, unbelievably, over 80 percent. To give you a better glimpse, perhaps, the standard question, what would you like to see done to improve the health care system, is rarely even answered. The few that do, say they wish dental care was included.

The program is very popular, and it has become a very substantial part of the Canadian culture and value system. In other words, I would say it is no longer just a government program. Indeed, in the 1988 Canadian General Election, which was dominated by the Canada-U.S. Free Trade Agreement as an issue, Medicare came close to determining the outcome. In mid-campaign, opposition parties suggested that Medicare would be taken away if Canada entered into a Free Trade Agreement with the U.S.

The government parties saw its popularity drop like a stone from a 14 percent lead to an 8 point deficit. Only a major effort supported by the father of Medicare to discredit that argument, permitted the government party to eventually reestablish their lead and win the election.

Now that the Canadian Medicare model is a popular success, does not mean that it would be necessarily an answer for you in the United States. There are, in my judgment, two reasons Americans might wish to proceed very carefully if they would wish to pursue a Canadian-type model.

The first revolves around the basic differences between the philosophies that guide our countries. And the second is that our system produces its own problems, and you must make sure that your system of government is well equipped to address those problems as they arise.

We believe the current system is best for us, but that does not mean that it is easily adaptable to other systems. Well-known American sociologist, Professor Seymour Lipsen, said, "Americans do not know, and Canadians cannot forget, that two Nations, not one, came out of the American Revolution. The United States is a country of revolution, Canada of the counterrevolution."

Canadians and Americans are so much alike. We live on the same continent. The majority speak English and dress in a similar manner. We do have some political and cultural differences going from our different democratic and institutional traditions.

From the very beginning of our Nations, these differences have been substantial. Your fathers dramatically called for the life, liberty and pursuit of happiness, while ours dryly wrote of the need for peace, order and good government.

Again, I quote Professor Lipsen, "Government power is feared in the south. Uninhibited popular sovereignty has been a concern in the north. Canada controls an area that is larger than its southern neighbor, but much less hospitable to human habitation in terms of climate and resources.

"It's geographical immensity and relatively weak population base have contributed to an emphasis on direct government involvement in the economy to provide various services for which sufficient private capital or profitable market have not been available.

"In America, the anti-sadist emphasis subsumed in the revolutionary ideology, was not challenged by the need to call on the

State to intervene economically to protect the Nation's independence against a powerful neighbor."

Canada's Medicare is a reflection of our philosophy and our political approach. I want to emphasize our system is unique. It is very different from the British, or the Swedish, or indeed, any other universal care system. It involves considerable compromise and cooperation: Federal and provincial cooperation, provider and patient cooperation, and public and private investment cooperation.

Let me examine the basic elements of the Canadian plan. Public administration—it must be administered by government.

Secondly, comprehensive coverage—it includes all medical services rendered by medical practitioners in hospitals, clinics, doctors offices. It provides patient care at standard ward level, upgraded to private or semi-private if declared medically necessary. Essential tests, drugs, as well as a broad range of out-patient services are supplied.

Universal coverage—all legal residents of a province are covered after a short waiting period which is 3 months.

Access—access is available for all medically required services. Doctors determine whether they are medically required. The system is portable; that is, residents are covered during a temporary absence from the province.

The system has a clear mixture of elements of public and private participation. Hospitals, while publicly funded for operations, depend on private contributions for their capital programs. Hospitals are non-profit corporations governed by independent boards, not boards appointed by government.

The vast majority of physicians are self-employed and operate on a fee-for-service basis. Indeed, in Ontario, of the $3.6 billion paid by the insurance plan to physicians, $3.4 billion went directly to fee-for-service.

Most other health professionals working outside of hospitals are self-employed with a varying degree of public financial contributions for their work. Medical testing laboratories are privately owned outside of hospitals. Ambulance services are often contracted to private operators.

Now, while the provinces govern the macro policy of the system, their principle tool is command of the purse strings. Policy by purse strings is awkward at best. In comparative terms, however, to date our approach has been beneficial, both in terms of health and cost control.

There is very little to choose between our two countries in the measurement of overall medical health outcome. One notable exception is the difference in infant mortality, much of that is that improvement—and indeed maternal mortality improvement—is likely attributable to the universal coverage and the accessibility.

Your per capita cost is about 44 percent higher than Canada's. Your administrative costs are about 2.5 percent of total cost. Sorry—our administrative costs are 2.5 percent of total cost, compared with your roughly 8.5 percent.

Our hospitals are on global budgets, and new capital expenditures must be approved by the province. Global fee increases for physicians, medical labs, etcetera, must be negotiated with the provinces.

We provide for greater coverage at less cost--8.6 percent of our GNP as opposed to your 11.4. Yet, at the introduction of Medicare in 1972, or at least when it became completed in 1972, the respective numbers were 7.4 percent for Canada, 7.6 percent for the United States.

That being said, we have no utopia. Compromise, so key to Canada's Medicare, has been both its strength and weakness. To date, fortunately for us, it has mostly been a strength. I believe only constructive compromise can alter the system to ensure that the growing weaknesses are successfully addressed.

One of the major institutional critics of the operation of universal health care and a key player in making it work, is the medical profession. While a substantial majority of the professions support Medicare, they also interface regularly with government and are vigilant about too much government control.

As one medical spokesman stated, "Any government that preaches accessibility and practices cost containment, is destined to seek ways to escape the political consequences of the paradox it has created."

Cost controls can result in leave in application of policy, create morale problems in professions, lead to long waits for some medical services, and slow the introduction to new technology.

Key policy pressure points have arisen that have to be addressed. Some examples would be—is there an expanded role for private capital? Is current coverage too broad? How should priorities change to address demographic shifts? Should the utilization of practice guidelines play a greater role in the system? What should be the priority of health care spending in relation to other key related areas, such as environment, housing, education and welfare?

To date, our problems have not led to a meaningful loss in public confidence. The cost growth pressures are serious and more creative measures are needed for constructive change, given the blunt instrument of tightening of supply.

The system has been in place for 20 years without a major review. Future changes must come through consensus, and government must play a leadership role in building a new consensus if Canadians are to enjoy, into the 21st century, the benefits they have enjoyed for the last 20 years.

I am confident a new consensus will be reached, but only after long and taxing debate. Belief in Medicare is strongly held by Canadians, and they will not tolerate deterioration without holding government directly to account.

I would be pleased, Mr. Chairman, to share any experiences I have as a former Deputy Minister in attempting to deal with the problems posed by the system, its people, and its contradiction.

[The prepared statement and attachments submitted by Mr. Scott follows:]

U.S. HOUSE OF REPRESENTATIVES

SELECT COMMITTEE ON AGING

NOTES FOR OPENING TESTIMONY TO THE COMMITTEE

GRAHAM W.S. SCOTT, Q.C.

PARTNER

MCMILLAN, BINCH
Barristers & Solicitors
Toronto, Ontario
Canada

WASHINGTON, D.C.

November 9, 1989

Mr. Chairman, Members of the Committee,

It is a privilege to have the opportunity to appear before you to discuss the health care system in Canada.

I should point out that my experience in the Canadian health care system arises from system and policy management. I am neither a doctor nor a health economist which has at times been considered both an advantage and a disadvantage. My experience arises from three years in the early 1980's as deputy minister of health in Ontario.

Ontario is Canada's largest political jurisdiction with 9 1/2 million people. Its medicare program is the most sophisticated in Canada. When I departed in 1984 direct health budget expenditures were 8 billion dollars and today exceed 11 billion.

Currently, I serve as the independent chairman of the Task Force on the Use and Provision of Medical Services. The Task Force is a joint endeavour of the Ministry of Health and the Ontario Medical Association focused on finding more efficient ways to deliver health care in Ontario. I practice public policy law in the Canadian law firm of McMillan, Binch.

Permit me a few words on the Canadian health care system which Canadians refer to as Medicare. The Medicare program developed over the period 1947 to 1972. By 1961 all Canadians had government financed hospital care and by 1972 all Canadians had government financed hospital and medical care.

Health Administration, under our constitutional arrangements, rests with the Provincial authorities but the Federal government has a substantial role to play through block funding. The block funding element provides the Federal government with the leverage to establish the broad policy parameters which guide the system. Of the total government share of health care spending just over 40% comes from the federal level with the balance supplied by the provinces.

As politicians, you are accustomed to polls and public opinion. It is probably fair to say that ongoing government programs seldom receive widespread public support or freedom from substantial criticism. Canadian medicare is a clear exception. Its popularity ratings evoke jealousy in the political arena. Support of the model is always above 90% and approval of day to day management is over 80%. The question: "what would you like to see done to improve the health care system?" is rarely even answered and the few that do usually express the hope that general dental care be included.

The program is popular and it has become a very substantial part of Canadian culture and value system. It is no longer just a government program. Indeed in the 1988 Canadian election dominated by the free trade issue, medicare came close to determining the outcome. In mid campaign, opposition parties suggested medicare would be lost if free trade with the U.S. was entered into. The government party saw its popularity drop like a stone from a fourteen point lead to an eight point deficit. Only a major effort supported by the "father" of medicare to discredit that argument permitted the government party to re-establish their lead.

That the Canadian medicare model is a popular success does not mean that it is the answer for the United States. There are in my judgment two reasons Americans might wish to proceed carefully if they are to pursue the Canadian model. The first revolves around the basic differences between the philosophies that guide our countries and the second is that our system produces its own problems and you must be able to address them in your system of government. We believe it is the best for us but that does not mean it is easily adaptable to other systems. The well known American sociologist Professor Seymour Lipset has said:

> "Americans do not know and Canadians cannot forget that two nations, not one, came out of the American Revolution. The United

> States is the country of revolution, Canada of the counterrevolution."

Canadians and Americans are to all the world so much alike. We live on the same continent, the majority speak English and dress in a similar manner. But we have some different political and cultural values flowing from our different democratic and institutional traditions. From the very beginning of our nations these differences have been substantial. Your fathers dramatically called for "life, liberty and the pursuit of happiness" while ours drily wrote of the need for "peace, order and good government". Again I quote Professor Lipset:

> "Government power is feared in the south; uninhibited popular sovereignity has been a concern in the north", and

> "Canada controls an area that is larger than its southern neighbour's but much less hospitable to human habitation in terms of climate and resources. Its geographical immensity and relatively weak population base have contributed to an emphasis on direct government involvement in the economy to provide various services for which sufficient private capital or a profitable market have not been available. In America, the anti-statist emphasis subsumed in the revolutionary ideology was not challenged by the need to call on the state to intervene economically to protect the nation's independence against a powerful neighbour."

Canada's medicare is a reflection of our philosophy and our political approach. Our system is unique! It is very different from the British or the Swedish or indeed, any other universal care system. It involves considerable compromise and cooperation. Federal and Provincial/provider and patient/public and private investment.

Let me examine briefly the basic legislated elements of the Canadian plan.

1. Public Administration

   Provinces are responsible for administration of the program which must be done by government.

2. Comprehensive Coverage

   Coverage includes all medically required services rendered by medical practitioners in hospitals, clinics or doctors offices; patient care at standard ward level upgraded to private or semi-private, if medically necessary; essential tests, and drugs as well as a broad range of out-patient services.

3. Universal Coverage

   All legal residents of a province are covered after a short waiting period.

4. Access

Access is available to all for medically required services. Doctors determine whether services are required.

5. Portable

Residents are covered during a temporary absence from a province of residence.

The system has a clear mixture of elements of public and private participation.

- Hospitals, while publically funded for operations, depend on private contributors for much of their capital programs. Hospitals are non-profit corporations governed by independent boards not appointed by government.
- The vast majority of physicians are self-employed on a fee for service basis.
- Most other health professionals working outside of hospitals, are self-employed with varying degrees of public financial contribution to their work.
- Medical testing laboratories are privately owned outside of hospitals.
- Ambulance services are often contracted to private operators.

While the provinces govern the macro policy of the system, their principal tool is command of the purse strings. Policy by purse strings is awkward at best.

In comparative terms, to date our approach has been beneficial in both health terms and cost control:

- There is little to choose between our two countries in the measurement of overall medical health. One notable exception is the difference in infant mortality. Much of that improvement is likely attributable to universal coverage and accessibility.
- Your cost per capita is about 44% higher than Canada's.
- Administrative costs are about 2.5% of total costs in Canada compared with your 8.5%.
- Hospitals are on global budgets and new capital expenditures must be approved by the province.
- Global fee increases for physicians, medical labs, etc. must be negotiated with the provinces.
- We provide for greater coverage for less cost. 8.5% of our GNP as opposed to 11.4% for the United States and yet we were at 7.4% and 7.6% respectively 20 years ago.

But we have no utopia.

Compromise, so key to Canada's medicare, is both its strength and its weakness. To date it has mostly been its strength but I believe only constructive compromise can alter the system to ensure that the growing weaknesses in the system can be successfully addressed.

One of the major institutional critics of the operation of universal health care and a key player in making it work is the medical profession. While a substantial majority of the profession supports medicare they also interface regularly with government and are vigilant about too much government control. As one medical spokesman stated:

> "Any government that preaches accessibility and practices cost containment, is destined to seek ways to escape the political consequences of the paradox it has created."

Cost controls are blunt instruments. They can result in uneven applications of policy, create morale problems in professions, lead to long waits for some medical services and slow the introduction to new technology. Key policy pressure points have arisen that will have to be addressed. Examples are:

(i) Is there an expanded role for private capital?

(ii) Is current coverage too broad?

(iii) How should priorities change to address demographic shifts?

(iv) Should the utilization of practice guidelines play a greater role in the system?

(v) What should be the priority of health care spending in relation to other key related areas such as environment, housing, education and welfare?

To date the problems encountered have not led to a meaningful loss of public confidence but cost growth pressures are serious and more creative measures are needed for constructive change given the blunt instrument of tightening of supply.

The system has been in place for twenty years without a major review. Future change must come through consensus and government must play a major leadership role in building a new consensus if Canadians are to enjoy in the 21st century the benefits of medicare as successfully as they have to date.

I am confident that a new consensus will be reached but only after a long and taxing debate. The belief in medicare is strongly held by Canadians and they will not tolerate deterioration without holding government to account.

I would be pleased to share any experiences I have had as a former deputy minister in attempting to deal with the problems posed by the system, its people and its contradictions.

Taking Care of Canada

As America agonizes about soaring medical costs and the millions who lack health insurance, Canada's system illustrates the prospects and pitfalls of universal coverage.

BY JULIE KOSTERLITZ

TORONTO—Canadians can't help betraying their amusement. All of a sudden, a nation that has played permanent understudy to its self-absorbed neighbor to the south is in the limelight. Congressional delegations, economists and journalists are flocking north to look at its health care system.

William L. Roper, the White House deputy assistant for domestic policy, was here, Canadians tell you. So were Reps. Fortney H. (Pete) Stark, D-Calif., and Willis D. Gradison Jr., R-Ohio, the chairman and ranking minority member of the Ways and Means Subcommittee on Health. The American Association of Retired Persons sent representatives, and just the other day, it was *The New York Times* and Sen. Dave Durenberger, R-Minn.

For the benefit of Americans who can't make the trip, some Canadians find themselves subject to command performances at conferences and hearings in Washington. "At first, Mohammed came to the mountain," joked Martin Barkin, Ontario's deputy minister of health. "Now, they want the mountain to go to Mohammed."

The Canadian system isn't new: The basics have been in place for about 20 years. Nor is the American flirtation with national health insurance new; it has been going on for at least that long. "Interest in Canada seems to come and go every five years," said Graham W.S. Scott, chairman of an Ontario health policy group.

This is the first of two articles on Canada's health care system. The second article will analyze the issue of whether elements of Canada's system might be adopted by the United States.

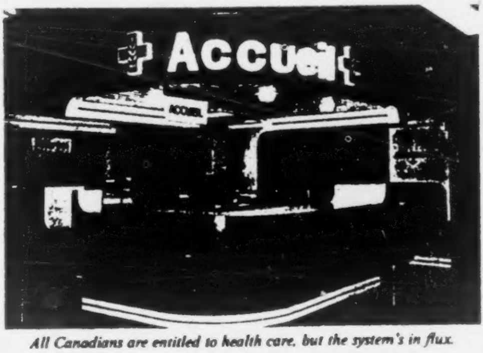
What has turned the spotlight on Canada this time is a mounting sense of crisis in the American health care system. A large and growing number of Americans lack health insurance—the estimates have ranged from 31 million-37 million. And the federal government and, increasingly, big business, worry that galloping health care costs could break the bank.

Canada, by contrast, not only offers all of its 25 million citizens comprehensive health insurance, but it does so at a far lower cost than the United States pays. In 1987, Canada spent 8.6 per cent of its gross national product (GNP) on health care; the United States spent about 11.2 per cent. Moreover, life expectancy and other key health indicators look pretty similar in the two countries. Actually, Canada does better than the United States in certain areas—it has lower infant mortality rates, for example.

What makes all this tough to ignore is that this is a country not too dissimilar from our own. There are, of course, important social and political differences. But in many economic and cultural aspects, as well as in demographic and medical trends, they are close enough so that—if you somehow forgot that Canada has its Francophones and that its Anglophones say "aboot" when they mean "about"—you could, for a moment, forget you'd left home.

Inevitably, some American policy makers are asking how Canada makes its health care system work—and whether a similar system would work in the United States. Congress already is starting to move on a proposal to change medicare payments to physicians by using cost controls loosely based on the methods of some of Canada's 10 provinces.

Not all Americans gaze north admiringly, however: Organized medicine looks askance at the controls placed on



Julie Kosterlitz

All Canadians are entitled to health care, but the system's in flux.

doctors and hospitals and has reacted sharply to the prospect of Canadian-style reforms in medicare. The American Medical Association (AMA) has launched a campaign to call attention to shortfalls in Canada's system, replete with newspaper advertisements and prepared remarks for Members of Congress to read into the *Congressional Record*. Rep. Butler Derrick, D-S.C., was one of several who sided with the AMA's view, telling his colleagues on June 20 that Canada's system has brought "growing waits for necessary surgery, degrading conditions for elderly hospital patients and an intrusion into the physician-patient relationship."

The conservative Heritage Foundation in Washington sent journalists a copy of a cover story in the Canadian newsweekly *Maclean's* on 63-year-old Charles Coleman, who died shortly after a heart operation in a Toronto hospital; the operation had been postponed 11 times. Stuart M. Butler, Heritage's director of domestic policy studies, wrote that the lesson from Canada is that government-run systems result in "diminished and rationed health care resources."

Brigitte Cavanagh

Ontario's Graham W.S. Scott
Americans are looking north again.

"Canadian-style" medical care thus means, to some Americans, an equitable and economical system, but to others, a welfare state run amok.

ACCEPTING LIMITS

Seen up close, the Canadian system is a good deal more complicated than either description would imply. To begin with, Canada's is a joint federal-provincial system that varies greatly by province. For another, it is, like the U.S. system, accommodating to an era of fiscal austerity.

How well the system functions depends, not surprisingly, on whom you talk to. Nevertheless, from more than a dozen interviews with government officials, physicians and hospital administrators, and talks with consumers in two provinces—Ontario, which is, in many respects, representative of trends throughout Canada, and Quebec, considered by many to be on the cutting edge of health care reforms—certain themes emerge.

- Canada has decided to ration medical care according to need rather than by income or work status, as the United States has done by default.
- Universal coverage is a widely cherished and politically untouchable feature of the health care system here.
- The presence of a sole payer for health care, the government, is key to the country's ability to restrain cost growth.

The government has held down the rise in health care costs by restricting doctors' fees and the availability of health care providers and some services, institutions and high-technology medical equipment. Because there's only one payer, the system spends substantially less on administration and advertising than the U.S. health care system spends.

The system doesn't always function smoothly, nor does the reality always match the rhetoric. Rationing according to need, for example, is anything but a science, and suspected failures—especially fatal ones—make instant headlines. And even though a government monopsony may be an effective agent of cost control, it can and has caused considerable rancor among physicians in some areas.

"Right now you have a bitter profession and a government that's indifferent to our bitterness," said Ted Boadway, director of health policy for the Ontario Medical Association (OMA).

Indeed, fiscal austerity by the Canadian federal government and some provincial governments and rising health care costs have produced a lot of finger-pointing. Left-wing critics, health economists and provincial officials tend to blame doctors for providing too many unneeded services and resisting change. Doctors blame "an entitlement mentality" that, they say, leads to public overuse of the system. Doctors also accuse government of making politically popular but economically untenable promises and then scapegoating doctors and hospitals when the promises can't be kept.

Even so, all parties respond to the notion of limits with a degree of cooperation and foresight that is unusual by U.S. standards.

"We take the approach that we're all in this together," said Ruth L. Collins-Nakai, a pediatric cardiologist in Edmonton, Alberta, and a past president of the Alberta Medical Association who serves on a new provincial task force on the future of health care. "Parts of the health care system fighting amongst themselves is not going to solve the problems." And Ontario's Barkin said, "There's almost a consensus on the direction changes should take between government, providers and citizens."

Roughly, the new conventional wisdom is that the bottlenecks in the system aren't caused by a shortage of money but by an inappropriate allocation of resources to high-tech medicine and institutions. Better accounting and more research are needed to track how money is spent and what results it gets, the thinking goes, and there's a shift in emphasis—from state-of-the-art medical and institutional care of the sick and injured to disease prevention and social welfare, economic and environmental policy. There's also talk of more community involvement in health care decisions and better public education on the costs and consequences of health choices.

If the research and cost-accounting part of this strategy parallels, and perhaps copies, American thinking, the "alternative health strategies" part may sound vague and idealistic to American ears. But Canadians insist that such an integrated approach is both tangible and vital, and many of the provinces have set up high-level commissions that are translating that approach into specific plans for the future.

Whether such changes can alleviate glitches in the system is anyone's guess. But given the extreme popularity of their universal, tax-financed health care, Canadian policy makers would rather face up to tough choices about how much care can be provided than restrict anyone's access to care. During consideration of Canada's free-trade agreement with the United States last year, when Canadians briefly and mistakenly thought their health care system might have to be dismantled, opinion polls showed a whopping swing against the agreement.

Americans shrink from the notion that care must be rationed; Canadians don't. It's not a question of whether either country must ration, they say, but rather how it is done. Canadians aren't shy about telling you that for all its shortcomings, their system represents the higher road.

"In Canada, when they thought one person did not get cardiac surgery in a timely way, that's front-page news," Barkin said. "In the U.S., when 37 million people don't get care, that's a small column in the back of your newspapers. Today's [newspaper] tells me you're even picking and choosing which ambulances you'll receive at an emergency department and which you'll send off somewhere else, like a scene out of Franz Kafka."

CONTROLLING COSTS

It all started in the western province of Saskatchewan just after World War II. After federal-provincial discussions of a possible national health insurance system went nowhere, that province in 1946 decided to forge ahead on its own, offering province-wide universal hospital insurance. Three years later, British Columbia and Alberta followed suit. In 1957, the federal parliament passed a law that made possible federal contributions to such plans, and by 1961, all provinces had qualifying plans.

Saskatchewan was the standard-bearer again with outpatient medical care, introducing the first universal medical care insurance program in 1962. Once again, the federal government picked up on the innovation, agreeing in 1968 to share costs for such programs. By 1972, all provinces had qualifying plans. "There was a certain social conscience that said, 'Gee, if they [another province] can do it, how can we not do it?'" said S. Vickery Stoughton, an American who is president of the Toronto Hospital Corp., which runs Toronto General Hospital and Western Toronto Hospital.

Under the federal-provincial system, the federal government sets basic standards, contributes about 37.4 per cent of the funds for the system and leaves the rest of the financing and decision making to the provinces. The federal standards hold that provincial plans must cover all essential medical services, encompass everyone, make services reasonably accessible and be portable—that is, cover Canadians when they travel or move.

Those features have endeared the system to Canadians. But it is the system's apparently superior ability to control costs that has riveted U.S. attention. In the mid-1960s, shortly after Canada's universal hospital insurance program got under way, both nations spent about 6 per cent of GNP on health care. In the two decades since, Canada's health care costs have risen by only about 3 percentage points as a share of GNP, while American expenditures as a percentage of GNP have nearly doubled, according to the Organization for Economic Cooperation and Development (OECD).

And here's another set of figures that has caught America's interest: In 1986, the United States was spending $1,926 per person for health care, according to the OECD, or about 41 per cent more than Canada's figure of $1,370 (U.S.).

How do they do it?

For starters, some health care economists say, Canada saves a bundle on administrative costs because, unlike America, it doesn't have payment systems run by hundreds of insurance companies as well as by federal and state government programs, each with its own rules.

Cardiologist Ruth L. Collins-Nakai
In Canada, "we're all in this together."

"There's a feeling that because of multiple payers, there's a duplication in effort," said Roberta J. Labelle, an assistant professor of economics at the McMaster Health Sciences Center in Hamilton, Ontario. "With a single payer, there are economies of scale."

Any American who has ever labored over a health insurance form, trying to figure out which expenses would be covered, couldn't help but admire the ease of doing the Canadian paperwork—it's about as simple as using a credit card. That ease also means sizable savings. Nearly 15 per cent of U.S. health expenditures goes for administrative costs, while in Canada, the figure is only 2-3 per cent, Labelle said.

Having the government run the insurance system also does away with the need for insurance company advertising and the charges that the companies tack on to reap a profit.

Canada also controls costs by keeping a tight grip on spending by hospitals and doctors. Hospitals in Ontario, which consume about 44 per cent of the province's health budget, receive a "global budget" to cover their costs. This budget, first established in 1969, is updated yearly to reflect general inflation—not medical inflation, which is typically much higher.

To stay within limits, "we've had to reallocate resources internally," Stoughton of Toronto Hospital Corp. said. For example, he said, in Ontario, the average hospital has about two full-time staff members (or the equivalent in half-time staff) per patient on a given day. Few American hospitals operate with fewer than four full-time staff members per patient per day, he said.

The Ontario government also limits the availability of hospital beds: The number of acute-care beds per 1,000 people has dropped from 4.2 in 1976 to 3.4 at present, Labelle said, although many beds have been shifted to other uses, such as long-term care. As a result of the limits, and the increased use of beds for patients requiring chronic care, she said, Ontario's occupancy rates run about 94 per cent, compared with the U.S. average of 60 per cent.

Access to big-ticket, high-tech medical equipment—for example, magnetic resonance imaging that allows doctors to see detailed images of cross-sections of the body, and lithotripters, which use shock waves to crush kidney stones—is also carefully controlled. Not only does government make sure that most sophisticated technology is confined to hospitals, it also exerts control, primarily through hospitals' operating budgets, over how many such machines there can be in the province and which hospitals can have them. In the United States, such decisions are made largely by individual hospitals seeking a competitive advantage in the marketplace and often lead to a proliferation of high-cost machines generating a lot of business—much of which is, arguably, unnecessary.

In Canada, hospitals have "no financial incentive to go out for all this stuff," Stoughton said. "I have a global budget.

Caring for Quebecois

QUEBEC—The old walled city here is home to Canada's first hospital, Hotel Dieu de Quebec, an imposing stone structure built in 1689 and still in business. Three centuries later, Quebec Province, set apart from the rest of Canada by its proud emphasis on its French language and legacy—and by its relative poverty—is still known for its firsts in the health area.

It is, for example, the only province that sets limits on physicians' gross incomes. The current limit for general practitioners is about $164,000 (Canadian). The province strictly limits the number of medical school admissions. It controls licenses for immigrant doctors, a policy that sparked a hunger strike recently by 20 immigrant doctors who were denied licenses. It also uses a carrot-and-stick approach to get doctors to practice where they're needed. Medical students who try to practice in doctor-packed Montreal get only 70 per cent of the standard fees.

Julie Kosterlitz

Quebec's J. Edwin Coffey
What about personal GNP?

Quebec also runs 154 local community service centers, where doctors work on salary, designed to improve access to care in poor communities for people who might otherwise show up in hospital emergency rooms for minor ailments or bounce from doctor to doctor. The centers offer a wide variety of services for the elderly, teenagers, the homeless and AIDS patients.

Quebec was also the first to launch a high-level commission to examine the future of health care. In April, the province unveiled a radical blueprint based on the commission's recommendations. Instead of separate boards of directors for each hospital, clinic and nursing home and community service center, the plan advocates regional boards to govern such institutions. Only members of the public—no health professionals—would serve on the boards.

Quebec's health care system evokes the same polar reactions in Canada that the Canadian system as a whole evokes in the United States. "Quebec has been in the forefront in doing innovative things in health care," said Ruth L. Collins-Nakai, a pediatric cardiologist in Alberta. And, with per capita health care costs at $1,472 (Canadian), Quebec is well below the national average of $1,525. (A Canadian dollar is now worth about 84 U.S. cents.) But Quebec also has some severe problems, such as long waiting lists for hospital beds and for specialized care. Some physicians regard Quebec as the medical equivalent of purgatory. In 1986, Quebec's doctors in private practice earned about $84,000 (Canadian), after expenses but before taxes, compared with physicians' national average earnings of $97,000. Doctors who approach the quarterly income limit sometimes shut their offices for a few weeks.

J. Edwin Coffey, an obstetrician and spokesman for the Quebec Medical Association (QMA), likens the system to socialism and says the government should control or subsidize health care only for the poor. "I could care less" about health care spending as a percentage of gross national product (GNP), he said. "The only question," he said, "should be, what amount am I willing as an individual to spend from my personal GNP?"

Others say the QMA represents a rear guard and note that the group has been bypassed by the government, which negotiates fees directly with two physicians' unions—something the QMA is trying to challenge in court. "When the system first came in, it was an anathema to doctors, a cancer on society," said Saul Pasofsky, director of the St. Louis du Parc community care center in Montreal. "Now, 95 per cent of them accept it."

If I don't have [extra business], I save money, and I look good financially. Our doctors spend time on that technology at another institution, and we refer [patients] there. . . . It works."

As the sole purchasers of health care, Canada's provincial governments have much greater control over spending for physician services than U.S. insurance companies and the U.S. government have.

American doctors can charge whatever the traffic will bear, though they may run the risk of after-the-fact challenges from insurance companies. American doctors also face tougher restrictions under the federal medicaid program, which serves some of the poor, and the medicare program for the elderly and disabled. But, unless a doctor agrees to accept medicare's approved fee as payment in full, the doctor can and often does ask elderly patients to pay the portion of their charges that medicare won't pay.

The system is vastly different in Canada. In Ontario, which is representative of many provinces in this respect, the provincial medical association and the government negotiate the sum of money available for physicians' services. Once that's set, the medical association sets doctors' fees.

Under the terms of Canadian law (and, since 1986, Ontario law), doctors are prohibited from charging patients more than the government will pay—a practice known as "extra billing." That restriction prompted an unsuccessful strike by Ontario physicians that resulted in continued hard feelings between doctors and the provincial government. In the meantime, provinces are also moving to limit the number of new physicians entering medical practice, on the theory that if there are more doctors, they will simply drum up more business for themselves. In British Columbia, an attempt to deny new physicians the billing numbers they needed to get government payment was struck down by the courts. But in Ontario, the government has already moved to limit the number of students graduating from medical schools as well as the number of residency positions for certain kinds of specialists in Toronto hospitals. Other provinces also are experimenting with controlling the supply of doctors. *(See box, this page.)*

QUEUING FOR CARE

Canada's system is not without its problems. Even though medical care costs Canadians a smaller share of the nation's GNP than Americans pay, the costs are eating up an increasingly large share of government spending.

In Ontario, one of the wealthier provinces, health care has risen from 27 per cent of the provincial budget in fiscal 1978

Toronto physician and author Michael Rachlis (standing)
"The public doesn't believe what the experts claim they know."

to an estimated 33 per cent in the current fiscal year. The provinces' financial burden has also grown as the federal government, which has its own financial problems, has tightened the formula that sets its contributions for health care.

Having government pay for health care makes it technically easier to control cost growth, but not necessarily politically feasible. Already, provincial governments' clampdowns on hospital spending have contributed to sporadic shortages of beds: Some patients must lie on stretchers in hospital hallways or do without some minor, but noticeable, amenities—*Maclean's* said some maternity patients had to bring their own pillows, for example.

The clampdowns also have resulted in waiting (or queuing, as Canadians say) for certain kinds of nonemergency care. In Ontario, the most-publicized bottlenecks have been in cardiac surgery, where waits of several months are not uncommon. Cardiac surgery, of course, varies in type from the life-saving to the nominally life-enhancing, and in theory, the highest priority is given to those in greatest need.

But the queue doesn't always function perfectly. That, for instance, was the message trumpeted by newspaper headlines when Coleman died last December. Whether the postponements caused his death, which occurred a week after surgery, is a hotly debated matter. But there's no question that the case stirred public passions.

In the aftermath of that case, Ontario increased the province's cardiac surgery capacity and set up a special committee to investigate better ways to coordinate the way all doctors select high-priority candidates for surgery. "We clearly did fall behind on cardiovascular surgery, and we're now quickly moving to bring that back up to standard," Barkin said. "But that was not a deliberate withholding of funding because we wanted to have a queue there, it's because we couldn't respond fast enough to certain changes in practice patterns." There's nothing wrong with queues for nonemergency care, Barkin said, so long as they don't get too long.

Provincial governments also have learned that as in the U.S. medicare program, even when doctors' fees are limited, over-all costs can skyrocket if there are no controls on the number of services that doctors perform.

After extra billing was banned, for example, "doctors' costs [in Ontario] leaped by a quarter of a billion dollars in a year and half," said Scott, who was the province's deputy health minister under the Conservative government before the Liberals came to power in 1985. "My own personal theory is that doctors felt they had to be more entrepreneurial to make money," said Scott, a Toronto attorney who is chairman of a government-OMA task force on medical services. Doctors also began billing patients privately for services that had been free but weren't specifically covered by national insurance, he said.

As the volume of services has continued to push up Canada's total costs for medical services, provincial governments have taken a tougher stance with doctors. Ontario has begun insisting that unexplained increases in the volume of services offered count against doctors in future fee negotiations.

The new course has been bumpy, at best. Last year, the negotiating process broke down in disputes over that concept, and the government unilaterally set the increase. Now, the two sides are trying to hammer out a new process for deciding future fees.

In the meantime, anecdotes circulate about some wealthy Canadians who don't want to wait for treatment heading over the border to hospitals in Buffalo, N.Y., or to the Cleveland Clinic in Ohio. There are also tales of physicians who have packed it in and moved south.

But there's general agreement that these instances are relatively few. In Toronto, people remember the brilliant children's plastic surgeon who moved to Texas in the wake of the failed strike. "He could turn the most horrible-looking monster creations into quite pleasant-looking children," Scott said. "But he would turn you away at the door if you didn't have his fee over and above what [government] would pay."

"He was a real superstar," Stoughton said. "The U.S. system is an enormously rich system, and real superstars can be well accommodated. We don't lose a lot."

Furthermore, Canadians confess that they're terrified of falling ill or having an accident while visiting the United States, for fear they'll be refused care or be bankrupted by expenses that exceed what their insurance will pay. They talk about loading up on private health insurance for travelers before a trip south, showing the same anxiety that Americans might have about getting sick in Mexico.

CHANGING THE EMPHASIS

The budget crunch and the development of pressure points in the system have given some ammunition to the Canadian system's critics. Conservatives and some physicians in both the United States and Canada see the problems as the inevitable outcome of a welfare-state mentality.

"When I went into practice, people were grateful [for doctors' services] to the point that they would bring me goods as a sign of gratitude," said the OMA's Boadway, a former family practitioner. "Over the past 20 years," he said, "there's been a cultural shift . . . , and people began to say, 'I'm entitled to, I demand to, and I will go' [to get medical care]. So people make more demands, and they do come to the doctor's office more."

Left-wing critics reverse the formulation. "What's wrong with the Canadian system is not the lineups and the queues, or that this is what happens when government runs things," said Michael Rachlis, a Toronto physician and co-author of a controversial book, *Second Opinion* (Collins Publishers, 1989). "The problem is physicians' clinical decision making . . . , which really gums up rational allocation of resources in the social policy area."

Many of the arguments in Rachlis's book are echoed in less-combative terms by officialdom. "The primary determinants of health are social policy, wealth and personal choice," Barkin said. People mistakenly attribute too much benefit, he said, to medical and hospital care, "to aorta coronary bypass, artificial hearts and all that kind of stuff that is glamorous and high-tech but doesn't buy you a lot of population health. . . . In fact, poverty may account for more ill health, and the correction of poverty may account for more good health, than all of the expenditure on our total health care system."

After several blue-ribbon government panels came to some of the same conclusions about the need for a major shift in emphasis, Ontario Premier David Peterson set up the Premier's Council on Health Strategy, made up of 7 cabinet ministers and 24 outside representatives, to translate those goals into concrete actions. "We believe there is sufficient money in the system now to have effective, well-managed [care], but we need to put different incentives in place, around how hospitals are set up and funded, about how physicians are paid, around where people are cared for, and different ways of organizing care," said Marilyn H. Knox, executive director of the council.

In May, the council's first big report set out health goals for the province. It has the rhetorical gloss typical of government reports everywhere, but the council says its lofty goals come with specific targets: making sure that 75 per cent of all health and social services are available in French in French-speaking communities, for example, and boosting the number of community health centers in Ontario by 50 per cent—and doing both by 1995. And, Knox said, the provincial government has made health a top priority. It also issued a technical report with some controversial recommendations on how to restructure the incentives in the current hospital-payment and physician-payment systems, and it proposed more experimentation with alternative delivery systems, including some modeled on American health maintenance organizations.

The province has also launched a joint task force with the OMA, headed by Scott, to tackle some of the thornier issues of medical-practice guidelines and the cost-effectiveness of expensive new drugs and technologies. Unlike many such groups, Scott said, this one decided against letting narrowly focused experts set the guidelines, and instead brought in a varied panel of experts. A striking result, Scott said, was that the group's recommendations on cholesterol screening were far more conservative than those produced by a U.S. National Institutes of Health "consensus conference." The American group advocated mass screening for cholesterol problems. The Ontario group found, Scott said, that "not only was mass screening not justified, [but] that if you compare the cost of mass screening per life saved, bypass surgery is cheaper." In fact, the study found, if the U.S. guidelines were followed in Ontario, they could add $1 billion to the province's $11 billion health budget.

"That's enormously instructive when one talks about health care costs, to think that something as minor as high cholesterol, which really is minor despite all the hype—it's a joke relative to smoking, for example, and heart disease—could cost as much as 1/11 of the entire health care bill," Scott said.

Ontario Medical Association's Ted Boadway, a former family practitioner
Since Canada adopted its program, people are demanding more medical care.

SUPPORTING THE SYSTEM

Whether the onslaught of initiatives will forestall a financial crisis or severe service cutbacks in the Canadian system remains to be seen.

Ironically, although they disagree on the roots of the system's problems and on solutions, both the critics on the Left, such as Rachlis, and mainstream physicians at the OMA worry that reforms could run afoul of public expectations. "Let's assume you had the best preventive system in the world," Boadway said. "People still get breast cancer and appendicitis. The threat is, we can't look after the people who still get ill . . . that we will be expected to do a job with the level of care and excellence people have come to expect and have a right to expect, and we won't be able to do it."

Rachlis blames the problem on public misinformation. "The public doesn't believe what the experts claim they know," he said. "While the experts say that at the margins, the next dollar put into physicians' services has much less influence on health than money put into other areas, the public believes that unless we're putting every last penny of their tax dollars into hospitals, that we'll all be dying like drought-stricken Ethiopians."

But even though the public's reaction to reform may be the big unknown in the future of the system, the public's support for universal, tax-financed health care is in no doubt.

"As Canadians, we've chosen to have a universal system, and any time there's talk about making changes to it, we will see the consumer groups rising up and being quite clear about what they think about it," Knox said. "It's something that's really quite sacred here."

The notion that consumers might be more sensitized to the cost of health care if they had to pay a share themselves has no political constituency. Indeed, the Ontario government has moved twice in recent years to further protect the public from out-of-pocket expenditures: in 1986, when it outlawed extra billing by doctors, and this year, when it abolished premiums for the universal outpatient care program in favor of a payroll tax on the province's employers.

Knox, like most of those interviewed, argued that requiring payments would create unacceptable barriers to care and undermine the concept of universality. "Yes, people appreciate costs when they pay them themselves, but when they don't get service, they also rise up and understand," she said. "It's a difficult one, but one point we're at here is that universality is not in question. The medicare system will be here, and we're not wanting to get into a two-tiered system where those who pay can get a different level of access from those who cannot." ☐

But Not for Us?

Although Canada's health care system appears to offer some better alternatives to the pitfalls of the U.S. system, most U.S. experts say such a system wouldn't work here.

BY JULIE KOSTERLITZ

Tell President Bush he needn't bother creating a kinder, gentler America, because it already exists. It's called Canada.

So goes the joke told these days among our neighbors to the north.

But as Americans study Canada's universal, tax-financed health insurance with an eye to reforming the U.S. system, health care experts on both sides of the border say the truth behind the quip makes wholesale adoption of a Canadian-style system here highly unlikely, at least anytime soon.

Social reformers in the United States, where at least 31 million people lack health insurance, envy the universality of the Canadian system. Washington policy makers and some large private employers have taken note of the comparatively low cost of the Canadian system: About 8.6 per cent of Canada's gross national product (GNP) is spent on health care, compared with 11.2 per cent here.

But for all the Canadian system's appeal, there are a host of subtle but profound societal and political differences between the two nations.

"It is a different country," said William L. Roper, the White House deputy assistant for domestic policy and a former head of the Health Care Financing Administration (which runs the medicare and medicaid systems). Roper, who visited Canada in January, said, "We have a common language, but there are important differences in values and cultural systems, and we must recognize that."

This is the second of two articles on Canada's universal health insurance system and whether elements of that system might be adopted by the United States. For the first article, see NJ, 7/15/89, p. 1792.

Aside from obvious differences, such as Canada's smaller population, its provincial system and its parliamentary government, there is a deeper difference: The U.S. emphasis on individualism and mistrust of government contrasts sharply with the Canadians' stress on the collective good and on government as its agent.

Canadians insist that the key to their success comes from having a single, universal health care system, controlled by the provincial governments. Many American experts, however, argue that solutions to our problems must be found within the current framework: a quasi-free-enterprise system in which various government, corporate and individual purchasers of health care use a wide array of health care providers, from health maintenance organizations (HMOs) to solo practitioners to for-profit hospitals.

Some argue that the American approach is superior and that the creativity and innovation that set it apart should be preserved. Others call it merely a concession to political realities here. "You can make a powerful argument that we'd be better off with a Canadian-style system, but the intellectual logic . . . is almost disjointed from reality," said Lynn M. Etheredge, a private health care consultant with some health insurance clients. "You can't put it together politically; there are far too many economic interests with a stake in the growth of the U.S. health care system."

John Ficek

Private health care consultant Lynn M. Etheredge
You can argue for a Canadian system, but "you can't put it together politically."

buy it, they do not want to be told what they can't have."

American analysts also say a Canadian-style system would mean an end to some innovations the U.S. system makes possible—benefits Canada has gotten for free. "They benefit from having us across the border, because we can do the R&D and they can use it," Roper said. In a Canadian-style system, he added, "there are some significant things we would forgo—innovation as to health care delivery systems, such as HMOs, and to the extent that we constrain spending too tightly, we'd constrain technological innovation."

U.S. critics of the Canadian system also contend that it has its own set of problems and that these are about to get worse as Canada faces fiscal challenges. Bed shortages may grow more acute, and old hospitals and equipment may face obsolescence. A recent decision by the Ontario provincial government to abolish patient premiums in favor of an employer payroll tax, they note, has some businesses hopping mad. "I think a lot of us have rose-colored glasses on as we look north," Schramm said. "We don't see a system that is facing the same pressures we are and the kinds of limitations that may obtain there."

"Canada can't continue to run the way they are," said Sen. Dave Durenberger, R-Minn., who visited Toronto in June. "The system is breaking down now."

Stoughton disagrees. Critics have long predicted the system's demise, he said, "and it hasn't gone to pot yet."

A MATTER OF TRUST

But perhaps the biggest reason a Canadian system wouldn't work here, U.S. analysts say, is Americans' abiding mistrust of their government. Although the government has been on the cutting edge of health care cost containment, critics argue that in a universal system, if push came to shove, it would succumb to public and special-interest pressures for more spending. "Government won't have the will to tackle the problems" of curbing costs, Schramm said.

Variations on the theme are echoed elsewhere. Although they concede that the Canadian system appears to offer doctors and hospitals less hassle and more stability, American doctors and hospitals don't trust their government to run the system. "I used to be a knee-jerk liberal who thought it was a great idea, but I've seen how government does the medicare program, and I see mindless bureaucracy," Carter White House aide Berenson said. "If you expand that three times over, I'd be very worried about it."

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Health Insurance Association's Carl J. Schramm
Americans expect much from medical care.

Hospitals are likely to take a similar view, especially because many of them are still making out quite handsomely.

"Ten years ago, we really felt like hospitals were public utilities," Etheredge said. "That psychology has changed quite a bit, and most are now independent businesses," and despite the attendant hassles, "most of them would still prefer to be free to be entrepreneurial."

Hospitals and doctors are also uncomfortable with the idea of collective bargaining with the governmen: The Canadian system, in which provincial medical associations bargain with provincial governments, is anathema to organized medicine in the United States. And U.S. physicians don't necessarily want the medical associations representing them. "I wouldn't trust the national or state medical association with my proxy," Berenson said, noting that the AMA claims only 50 per cent of doctors as members.

Employers also share this mistrust of government. Despite their panic over burgeoning health care costs, employers have historically eschewed any government proposals to control physician and hospital costs. In 1983, for example, when Sen. Edward M. Kennedy, D-Mass., and Rep. Richard A. Gephardt, D-Mo., proposed a system that would limit the amount any health insurance program would have to pay hospitals, not one company stepped forward to endorse the plan, a congressional aide recalled. Nor have employers raced to endorse Kennedy's more recent bill (S 768) that would require all employers to offer health insurance, although the plan would arguably address the concerns of big companies that many smaller employers have been getting a free ride at their expense. (The Senate Labor and Human Resources Committee narrowly approved the bill on July 12.)

"If they were being at all rational, all payers [employers and the government] would be on one side and providers on the other," Etheredge said. "That's never happened in the political debate in the U.S. The business community, for its own ideological reasons, has been on the side of providers. Whatever the problem, they say, government regulation can't be the solution. So [business keeps] fighting for the right of providers to continue to rip them off. At least they're paying the price of their principles."

A few companies, primarily automobile manufacturers such as Chrysler Corp. and Ford Motor Co., have begun broaching the idea of national health insurance, but so far, the calls have been limited. Furthermore, critics say, troubled automakers have a particular self-interest: They have a higher-than-average ratio of retirees to active workers and, having overpromised benefits to their retirees, now want to shift the costs to the public and other employers. "It's Chrysler's second bailout," Schramm said.

Most employers believe that they can solve their problems better on their own. "Everyone's capable of doing it in different ways, I submit," Allied-Signal's Duva said. "Even smaller companies can do a lot, although they may not be able to get the same financial terms we did. I think limiting how [companies] do this to any one way is incorrect. I think, generally speaking, the private sector can do things more cost-effectively," although managing health care costs might be an exception, he said.

Canadians don't share Americans' deep mistrust of government or their go-it-alone mentality. "When I came up here," Stoughton said, "the thing that struck me was that there's a social conscience in this country that says, 'We value the collective good over the individual.' Canadians trust government, and it's part of the social fabric of this country. That kind of societal attitude must have made it easier to introduce a universal health care system, and it has become the most popular social program in this country, bar none."

LOOMING CRISIS

Behind the arguments, however, is a palpable ambivalence among Americans.

The same people who argue that neither health care providers nor the public would accept the structures of national health insurance go on to tell you that the current system doesn't work well and that something has to give. "We need to take one lesson from the Canadians," Roper said. "We need to get serious."

But there's scant agreement on how to tackle the twin problems of access and cost control. In the past six months alone, at least a half-dozen groups have unveiled alternative proposals for accomplishing this. In January, *The New England Journal of Medicine* actually featured two different plans: one, by Physicians for a National Health Program, a national organization of about 1,250 doctors based in Cambridge (Mass.) Hospital, called for a Canadian-style system of health care budgeting; the other, by Alain Enthoven and Richard Kronick of the Stanford University Graduate School of Business, would oblige employers to pay 80 per cent of health costs of all full-time workers and require government to act as "public sponsors" or brokers for the care of everyone else.

Many politicians, business executives and health care providers maintain that the two goals can be achieved incrementally by building on the present system. Most care could be privately financed and managed, but government's role would be expanded to provide incentives to business to expand coverage of workers and manage costs better. Government would also have to broaden subsidies for those who have no other access to health insurance.

Roper, Durenberger and Berenson are among those who still express hope in the cost-cutting incentives of competition and in alternative health plans, such as HMOs, which receive a flat fee per patient to manage all their health care needs. "If, in the U.S., doctors were willing to group up and take on the provision of care, and the payment system rewarded them for that, that's our control mechanism—that's the way we can get the market to work in this country," Durenberger said.

Government would have to police the market, Berenson said, to make sure that the savings "were based on performance" and not achieved by skimming off the healthier patients.

Stoughton, however, is dubious. "I was educated in the University of Chicago MBA program, which is extraordinarily free-market-oriented, but I've always felt that trying to apply economic principles to social programs didn't quite fit, and it doesn't," he said. "Unfortunately," he added, in the health care arena, "competition does not work."

In the meantime, Some of the changes already under way are not unlike the constraints that analysts have been saying Americans would never accept.

For example, the powerful vested interests in the health care system are losing some of their unrestricted power. Since 1983, the medicare program has imposed substantial regulation on hospitals and is now in the process of overhauling the way it pays doctors. In fact, the legislation to institute "expenditure targets" that would put the brakes on year-to-year increases in medicare spending on physicians is modeled loosely on the approach taken by some Canadian provinces.

Just as significant, Congress has established three agencies to advise it on hospital, physician and, most recently, prescription drug payment policy that have come to serve as intermediaries between the care providers and the government. "What's interesting is the extent to which [these agencies] have become the American institutions for negotiating," Etheredge said. "They are, in fact, becoming very influential."

Some large private employers are also demanding and getting concessions from insurance companies and providers. Over time, as more large employers have turned to self-insurance for health benefits—about 60 per cent are now self-insured—the insurance industry has dropped much of its risk-taking function and become either a claims administrator or a sort of watchdog for hire to review employees' use of health care with an eye to trimming waste.

Richard A. Bloom

Sen. Dave Durenberger, R-Minn.
Canada's health care system "is breaking down now."

Perhaps even more telling, employers are putting restrictions on employees' unfettered use of insured health care. The constraints are perhaps not as draconian as the several months' wait for elective surgery that patients face in Canada, but they are often unpopular in their own right. At Allied-Signal, where the new cost control plan includes financial incentives for employees to use approved physicians, Duva acknowledged that there were "some initial rough edges from an employee acceptance standpoint."

It is not clear that even these efforts will have the desired result—for the companies or for the economy. Duva, though optimistic about the results of the new cost containment plan for Allied-Signal's 44,000 enrolled workers, notes that it doesn't include most of the company's 21,000 unionized employees or any of its 50,000 covered retirees, who are the heaviest users of health care.

Even if many large companies succeed in trimming their costs, some skeptics believe that in a system with multiple payers, the costs will turn up somewhere else—in the parts of the system that are unregulated, or in the bills of those payers that don't have much market clout.

"You can't go at this piecemeal, and that's what's going on," Stoughton said. "The federal government's approach is, Let's do a little on managed care, and let's have some competition in the system. But, . . . if you don't fence the system in, the smart providers out there are going to take advantage of all the leaks."

Employers and the government admit they're worried. "Personally, as I see it, this is the last hope of corporate America if we want to keep [health care coverage] in a private setting," Duva said of the latest generation of employer cost containment efforts. "We have three-five years' time."

Gradison said he is "pessimistic in one sense. History suggests we're crisis-oriented, and I don't think there's public awareness that there's a health care crisis right around the corner." An immediate sign, he said, are the hospitals threatening to shut down money-losing trauma units, which, along with emergency rooms, tend to have a high percentage of uninsured and low-income patients.

"Some people say, 'Let's give hospitals money for their trauma units,' but that misses the larger point," Gradison said. "I hope it doesn't take a crisis to force action, but it might." □

As for the solutions, however, there is little precision and scant consensus. A variety of policy makers have expressed interest in the notion of "managed competition," in which the government provides incentives for all purchasers of health care to contract with lean and efficient organizations, such as HMOs and their variants. But no one seems certain exactly how this might come about and how it would work.

Most concede that even an improved free-market system would probably not provide the same universality or control of costs that the Canadian system provides. Americans, they insist, aren't willing to accept the sacrifices this would entail.

FRAGMENTED SYSTEM

Few U.S. experts familiar with the Canadian system will deny that it has some attractive features. Beyond the universality of access and the cost control features are less obvious ones—some defying American stereotypes about national health insurance.

Often thought of as centralized and rigid, national health insurance in Canada leaves most basic health policy decisions to provincial governments. "Their system is more federal than ours," said Rep. Willis D. Gradison Jr. of Ohio, the senior Republican on the Ways and Means Subcommittee on Health. "There are substantial variations from province to province." At the same time, strong federal requirements of universal, comprehensive and portable coverage guard against the vast state disparities in coverage and eligibility in the U.S. medicaid program.

With most of Canada's health care financing and public health issues concentrated in relatively few hands at the provincial level, the provincial governments can, and increasingly do, take a more comprehensive approach to health care policy than the United States does.

In this country, payment decisions are not only divided between government, employers and individuals, but are also fragmented between different levels of government: Washington is responsible for medicare, the program for the old and disabled, and shares responsibility with the states for medicaid, which primarily covers the poor. Beyond that, cities and counties typically finance a variety of public hospitals and clinics for those who fall through the cracks.

Even at the federal level, the approach is fragmented. In Congress, different aspects of health care fall to different committees, which jealously guard their turf and tend to act independently. Within the bureaucracy, the Public Health Service is responsible for both advanced scientific research and more basic disease prevention and health promotion, and the Health Care Financing Administration not only administers medicare and medicaid but tracks broader health economics issues. The two operate like giant ships passing in the night.

Joseph W. Duva of Allied-Signal Inc.
Companies "have to change how they deliver care."

Richard A. Bloom

The Canadian system's comparatively simple administration also belies part of the popular image of national health insurance as more bureaucratic and intrusive than a free-market system. American physicians and hospitals, for example, complain about the growing gantlet of insurance, HMO and government rules that they must negotiate.

"The positive thing in the Canadian system is that you don't have to distinguish patients according to payer class," said Robert A. Berenson, a Washington internist who was an assistant director of the Domestic Policy Staff in the Carter Administration. In the United States, he noted, "every payer is looking after their own interests, so it makes sense from their own standpoint. But, taken in the aggregate, it's a crazy-quilt mess."

With multiple payers, "it's a real problem to practice medicine," he said. "You're continually caught in the middle. My malpractice insurance company makes me go to seminars or they'll cancel my insurance. The seminars tell me to suspend my clinical judgment and order tests so they'll know I have all the documentation. Simultaneously, the HMOs penalize me for ordering these same tests. Insurance has exclusions for preventive and routine care, which makes no sense from a medical standpoint, . . . and patients expect me to lie on their behalf" so that they can get such care paid for by insurance, a demand that "sets up weird ethical problems."

Just as bad, he said, is the lack of portability of employer health plans. "Time after time, it has happened that because a patient's job has changed, I might not be their doctor anymore. People moving across the system is not good medicine and has to have significant transaction costs," he said.

Canadian physicians agree. "We probably have more freedom" than American physicians do, said Ruth L. Collins-Nakai, an Edmonton (Alberta) pediatric cardiologist, "because in the States, you have all those third-party [insurance plans] breathing down their backs."

Hospitals face some similar problems. The American Hospital Association, for example, has said that the typical hospital in the United States must already contend with 45 regulatory institutions. And though many hospitals are making out quite well in the brave new world of entrepreneurial health care, others are struggling. Many inner-city hospitals, for example, are overloaded with medicaid and uninsured patients other hospitals won't take—often the sickest of the sick.

Canadian doctors and hospitals say they appreciate not having the problems their American counterparts face in contending with the uninsured and poor who cannot pay their bills. "I worked in [Boston] and had great difficulty turning away sick kids" who lacked insurance, Collins-Nakai said. "I couldn't do it."

Having government administer the program would also take some of the heat off employers, which insure about 136 million workers and dependents who are increasingly alarmed by the rates of increase in the costs they face. Adding to workers' sense of urgency is their new awareness of the huge and long-hidden costs of health insurance promised to retirees in years past. Part of generous early-retirement packages meant to help trim payrolls, these promised health plans for retirees under age 65 have become a major cost item. Just how major has been driven home by a recent Financial Accounting Standards Board decision that will require companies to list these costs on their balance sheets at the time they're promised—not merely as they're paid.

Employers, slow to confront costs, have been scrambling to catch up. In the meantime, they complain that they are subsidizing the uninsured, the small businesses that hire them and even the tightfisted government programs.

And, having already seen their early efforts at cost containment fall short, companies are beginning to recognize that future solutions will have to be tougher. "Our prior cost-containment efforts worked only for a short term," until providers found the loopholes in the system, said Joseph W. Duva, corporate director of employee benefits for Allied-Signal Inc., a New Jersey-based manufacturer of aerospace and automotive equipment that recently launched an aggressive new health care cost-control program. "If companies have gone through the process we have, they would recognize they have to change how they deliver care."

MAKING A DIFFERENCE

But if the Canadian system appears to offer some better alternatives to the various pitfalls of the American system, American experts almost uniformly argue that such a system wouldn't work here.

Canada is different, they say. It has just a fraction of our population and 10 provinces to our 50 states, which presumably makes a universal health care system easier to manage.

The Canadian form of government is also different. Parliamentary politics at both the federal and provincial levels makes for a greater unanimity of purpose in government than does the American system of separation of powers between the executive branch and the legislative branch—which itself has a fractious bicameral structure. In the Canadian system, when one party has a majority of seats, "you can pass a law faster than anything I've ever seen," said W. Vickery Stoughton, an American who for the past eight years has been president and chief executive officer of Toronto General Hospital, which recently merged with Western Toronto Hospital.

The parliamentary system also insulates rank-and-file elected officials from special-interest pressures to a greater degree than the U.S. system does. Interest groups, "instead of lobbying individual members [of Parliament], are more likely to go to the cabinet ministers," said Steve Clarke, senior legal specialist in American-British law at the Library of Congress. Unless the government collapses, Canadian elections are held only once every five years, and campaigns, which last a few weeks at most, are financed publicly and are subject to expenditure limits, Clarke said.

That's no small point, say those who doubt that a Canadian-style system would work here. There are large, entrenched and well-financed interests—hospitals, doctors, the insurance industry and a whole network of workers and suppliers—that could be expected to resist a system in which government pays the piper and calls the tune.

These groups not only exert influence in Washington but also have economic roots that sink deep into the American economy. "We have a health sector that is very large and very economically oriented—very entrepreneurial," said health consultant Etheredge, who noted that "16-17 per cent of the expansion of GNP comes from the growth of the health sector. Hospitals are the largest employers in most metropolitan areas. U.S. health care is the eighth-largest economy in the world, with $500 billion a year in revenues, [and] the health sector is lots larger than the whole Canadian economy."

There is also the multibillion-dollar health insurance industry to contend with—even though the business has not been very profitable in recent years. In Canada, no private insurance can compete with the government plan. Although the government works through nonprofit intermediaries to administer claims, as the U.S. medicare program does, there is nothing like the private insurance industry that exists here. Nor, Canadians say, is there anything like the kinds of administrative and advertising costs the economy incurs in dealing with diverse, mainly for-profit insurers.

Brigitte Cavanagh

Toronto hospital chief W. Vickery Stoughton
In health care, "competition does not work."

"To make their system work, the Canadians had to outlaw private [health] insurance," Gradison said. "We're not going to do that in this country. . . . It's not even on the table."

Having instituted their system in the mid-1960s, American analysts argue, the Canadians also didn't have to contend with the kind of heightened public expectations about medical care that exist in the United States today. "The diet [of health care consumption] of the average American consumer is much different now than it was then," Carl J. Schramm, president of the Health Insurance Association of America, said.

In fact, it's an article of faith here that neither providers nor the public would accept the trade-offs implicit in a system of universal, tax-financed care, such as the waiting lists for elective surgery that have sprung up in various provinces.

Those who make that argument are unmoved by a recent study of public opinion polls by Robert J. Blendon, chairman of the health policy and management department at the Harvard University School of Public Health, showing that a greater percentage of Americans than Canadians are unhappy with their national health systems and that Americans by a large margin prefer the Canadian system to their own. Those results, the White House's Roper argues, reflect responses to loaded questions.

"Can you imagine people settling for waiting a month for surgery when they get so angry at waiting an hour to see the doctor?" asked Thomas R. Reardon, a Portland (Ore.) physician who has visited Canada several times as a member of the Physician Payment Review Commission, which advises Congress on medicare physician-payment issues. "Canadians have a less-demanding, more-European culture," he said. "They don't have to have everything yesterday."

Of course, these critics acknowledge, the 31 million or more Americans without health insurance and the financial means to buy it already face waits for care or forgo it altogether if they can't afford it. But that concern doesn't evidently rank as high on America's list of pet peeves. "We do ration health care in this country by [tying it to individuals' financial] resources," said Reardon, a member of the House of Delegates of the American Medical Association (AMA). "We're the only Western nation in the world that hasn't solved the problem of universal access. It's a me-oriented society—'I have mine, let them get theirs.'" Rationing care to the rich, the middle class and the poor alike won't fly here, he said. "If they can

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November 28, 1989

The Honourable Edward R. Roybal
Chairman
U.S. House of Representatives
Select Committee on Aging
Washington, D.C. 20515
U.S.A.

Dear Mr. Chairman:

Thank you for your letter of November 17th and for enclosing additional questions.

I thoroughly enjoyed the opportunity of appearing before your Committee and hope that my testimony was of assistance to you.

With regard to the question of financing, I am somewhat reluctant to comment on the proposals in USHealth due to my lack of familiarity with the details of the current financing of existing plans in the United States. In any event in the time available I would not be able to undertake the considerable effort to provide a meaningful analysis for you.

In relation to the question of the politics of comprehensive reform I can say on reflection that they are not easy in the initial stages. As I pointed out in my testimony, comprehensive health care came to Canada in stages from the 1940's to the beginning of 1970.

The two most phenomenal developments were the comprehensive hospital care developed in the late 1950's and the comprehensive medical care introduced in the late 1960's. The provision of substantial federal funding to provinces engaged in the programs that met basic federal guidelines proved crucial to move the provinces that had not yet committed themselves. In all cases there was substantial opposition from the medical profession although in general they were quick to accept and work within the system once it was in place. The principal advantage for legislators arises from the general satisfaction of the community at large and the business community which strongly support the plan. From an economic point of view while Ministers of Finance and Provincial Treasurers may be concerned about the growing cost of health care they also have at their disposal the ability to generally control funding on a global basis with the result that they have enjoyed a reasonable success in holding down increases in health care costs as a percentage of the gross national product.

As to the issue of cost containment it would be wrong to suggest that Canadian provinces have found any particularly successful formula other than that of global restraint. In effect, the basic system is funded on a global basis involving some adjustment relating to inflation and supplemented by additional funding for new programs and new technology. The general determination of where and how this extra funding will be applied is influenced by policy groups usually put together by the Ministry of Health and involving public advice from provider groups. In general the provider groups will recommend far more than the government is prepared to pay for and this generally results in reworking of recommendations to meet government's fiscal goals.

Due to the lack of resources available to me I cannot do an appropriate financial assessment of the USHealth program and therefore comment specifically on its ability to limit growth in the GNP. I can say, however, that I believe that the demand for health services in countries with a high standard of living such as ours will continue to be considerable and only through comprehensive coverage combined with opportunity for funding controls is there much hope of maintaining health care costs at a reasonable percentage of GNP. Given the huge sums currently payable for administrative costs in the U.S. system as opposed to the Canadian system, this in itself should provide considerable cost savings which could be directed to health care and health outcomes or to simple cost savings. It certainly seems more than reasonable to me that a comprehensive reform should realistically result in containing the growth of health care as a percentage of GNP while at the same time improving the quality of health care available to Americans. As to what Americans would have to give up, I can only say that clearly there would have to be some trade-offs. Such trade-offs would obviously involve some limitation on the activity of private insurance companies and unquestionably some limit on the proliferation of medical equipment and technology.

The trade-offs should result in no bottom line effect on the quality of life or quality of medical outcome for the American seeking health care and indeed should produce quality care for the many Americans not currently covered.

In the area of long term care I am reluctant to provide any advice. While our comprehensive system does provide a reasonable base of support for the elderly who require chronic care I am not satisfied that we have found an adequate approach to dealing with the growing needs for long term care in Canada.

I regret the necessity of these general responses but the combination of a limited timeframe and limited research resources make it difficult for me to provide more complete answers to your questions.

My very best wishes in your deliberations.

Yours sincerely,

Graham W.S. Scott, Q.C.

GWSS:kb

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November 15, 1989

The Honourable James H. Bilbray
U.S. House of Representatives
Washington, D.C.
20515

Dear Congressman Bilbray:

Re: Canada's Health Insurance Program - Doctors' Incomes

During my testimony before the Select Committee on Aging on Thursday, November 9, 1989, I undertook to provide you with some information with regard to Canadian doctors' incomes.

In my testimony I believe I said that it was my recollection that Canadian doctors' incomes on average ranged from about a low of $84,000 in one province to a high round $120,000 in Ontario. I failed to give a time frame for that information and I am pleased to both correct the information I gave at that time and provide it in a context.

The information I was alluding to is contained in a Summary of the Canadian Healthcare System put together by the Canadian embassy in Washington. It refers to 1986 Revenue Canada figures quoting the incomes in U.S. dollars. In 1986, the average gross income for Canadian doctors was $110,100; the highest average income being in Ontario at $126,200. The tracking of doctors' incomes by Revenue Canada is the longest continuing source of information and the numbers are considered very conservative.

It should be noted in considering the income figures that liability insurance costs are substantially lower in Canada then in the United States and that the simplicity of the claim and payment structures is such that overhead is very low and in these terms, it is important to note that net income before taxes is probably a much higher percentage of gross income than would be realizable by physicians in the United States.

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The Honourable James H. Bilbray
November 14, 1989
Page 2

I am enclosing for your information a review of Canada's Health Insurance Program published by the Canadian Embassy.

If I can be of any further assistance, I would be delighted to assist.

Yours sincerely,

Graham W.S. Scott, Q.C.

GWSS:kb
Enclosure
GWSSHONBILBR:VWTAX

cc: The Honourable Edward R. Roybal
Chairman of the Select Committee on Aging
U.S. House of Representatives

Canada's Health Insurance Program

"We place great emphasis on our health and social programs and have done so for many years....We are proud of the fact that each and every Canadian has the right to medical service."

The Hon. Perrin Beatty,
Minister of National Health & Welfare

The Evolution of the Program in Canada

Canada's first pre-paid health insurance plan was an agreement made in 1665 between surgeon Etienne Bouchard and the settlers of Montreal: for a premium of 100 sous a year, he would give a settler and his family any treatment they needed, without further charges. Some three hundred years later, a program of taxpayer-financed, pre-paid, universal health insurance, made up of interlocking provincial health plans, was established in Canada.

After the Second World War, the federal and provincial governments met to discuss reconstruction measures, including health insurance. The federal government wanted every province to establish its own health plan so that all Canadians would have coverage, and it offered to share the provinces' costs. No agreement could be reached. Some provinces chose to act without federal funds: Saskatchewan was operating a public, universal hospital insurance program by 1947, British Columbia had a similar program by 1949 and Alberta and Newfoundland had hospital plans that gave partial coverage.

But other federal-provincial discussions followed, and resulted in Canada's national health insurance program as it exists today.

By 1961 all provinces and territories had public insurance plans that provided comprehensive coverage against the cost of hospital care; 99 percent of the population was covered. By 1972 all of the health plans had been extended to include doctors' services. Individuals were free to choose their physicians.

The Canada Health Act, passed in 1984 to consolidate earlier federal legislation [1], establishes the criteria and conditions which the provinces must meet in order to qualify for their full share of federal funding for medically necessary hospital and physician services. Its terms ensure that the provincial plans together comprise a national program of pre-paid, publicly administered health insurance, and that each plan meets standards of accessibility, universality, comprehensiveness and portability.

Provincial Flexibility

The provinces and territories have considerable flexibility in determining how their plans are administered and funded. They are also free to cover services which are not provided for under the national plan, such as prescription drugs, cosmetic surgery, dental care, optometry and physiotherapy. Extra-billing and user charges are discouraged by the Canada Health Act and are subject to dollar for dollar reductions in the federal contribution to a province's health care

Basic Elements of the Canadian Program

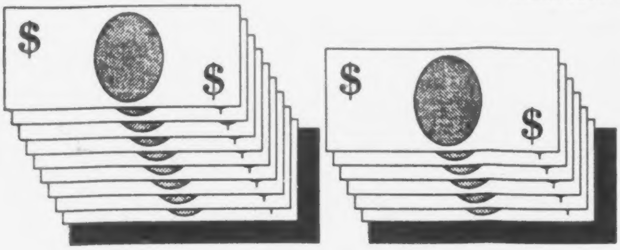
Under the Canada Health Act:

- *Administration is public and non-profit.* The administrative authority is designated by and responsible to the provincial government.
- *Coverage is comprehensive.* Insured physician services include all medically required services rendered by medical practitioners in hospitals, clinics or doctors' offices. Insured hospital services include in-patient care at the standard ward level, unless private or semi-private accommodation is medically necessary, and all necessary drugs, biological products, supplies and diagnostic tests, as well as a broad range of out-patient services. Psychiatrists' services and all mental hospital services are fully covered. Certain surgical dental procedures performed in a hospital are also covered. There are no upper limits on care, as long as it is medically necessary.
- *Coverage is universal.* Each health plan includes all legal residents of the province. After a waiting period (or minimum period of residency) of no more than three months, residents are eligible for coverage.
- *Access to insured services must not be unreasonably restricted.* No one may be discriminated against on the basis of poverty, age or ill health. Deductibles and most user fees are prohibited. No one may be denied access to medically required services. Doctors determine whether services are required.
- *Benefits are portable.* Benefits are payable for a health service covered by the plan even if that service is received during an insured person's temporary absence from his province of residence.

Per Capita Health Care Expenditures

1988, in U.S. dollars

Source: OECD



insurance program. However, provinces and territories are allowed to charge patients for meals and accommodations in chronic care facilities.

Payments to doctors are negotiated between the provincial or territorial authority and the organization representing medical practitioners, in most cases, the provincial medical association. Doctors are usually paid on a fee-for-service basis, although they may be paid through other methods such as salaries or contracts.

Funding

Spending on health care varies from province to province, from about one-fifth to one-third of the total provincial budgets. The provincial plans are primarily funded out of general tax revenues, which may be supplemented by sales taxes, taxes levied on employers or premiums paid by individuals. As of January 1, 1990, only Alberta and British Columbia will collect premiums. The federal government financially supports the provincial health plans by means of block transfers of funds; federal contributions are calculated independently of provincial costs. Health care accounts for 25.9 percent of the 1989-90 federal budget.

Until 1977, federal contributions were linked to the cost of insured health services, roughly matching provincial expenditures dollar for dollar. This financing arrangement presented problems for both the federal and provincial governments. Because the federal contribution was linked to insured services, the provinces were unable to allocate it as they wished; for example, federal funds could not be spent on extended health care services such as those offered in nursing homes and chronic care facilities. The federal government objected to the provinces having, in effect, control over increases in federal spending on health insurance.

In 1977 a new formula replaced the old: federal contributions would no longer be directly related to provincial costs but would be based on a three-year moving average of the GNP. The contribution to insured hospital and doctors' services takes the form of a system of block grants and the transfer of personal and corporate income tax points to the provinces. A further annual grant is made toward extended care provided outside hospitals. This grant is based on a per-capita amount indexed to the growth of the GNP.

The changes limit increases in the federal contribution; when the costs of health care grow at a faster rate than the economy as a whole, the provinces must absorb more of the costs. In 1982, the federal government further restricted the growth in transfer payments. The 1989 federal budget guaranteed the provinces a growth rate at least equal to the inflation rate.

The change to block funding provided a more stable financial footing for health programs so that both levels of government are able to plan their expenditures. It also allowed the provinces more flexibility in spending their health care dollars since federal contributions are no longer tied to institutional and physician services.

Cost Control

In a 1986 article in the *New England Journal of Medicine*, John Iglehart wrote that Canada's health care system "...has for years demonstrated a capacity to deliver universal, high-quality medical care for considerably less than the cost of care in several other Western industrialized nations, particularly the United States."[2]

According to preliminary estimates from the Organization for Economic Cooperation and Development (OECD), Canada spent U.S. $1,580 per person for health care in 1988, while the United States spent $2,268 per person, about 44 percent more. Both Canada and the United States were spending about 6 percent of their respective GNPs on health care in the mid-1960s. Since then the cost of health care in the U.S. has almost doubled: in 1987 the U.S. spent 11.2 percent of its GNP on health care. The cost of health care in Canada has increased by less than half: in 1987 Canada spent 8.6 percent of its GNP on health care.

Canada's national program of health insurance has a low costs-to-benefits ratio that commercial insurers cannot match.

- Administrative costs make up about 2.5 percent of the total cost of the Canadian health care system, while in the United States administration accounts for 8.5 percent of the total.
- Universal, pre-paid coverage on uniform terms saves the insurer the costs of estimating risk status, setting differential premiums and deciding who

should be covered. Hospitals and doctors' offices also have reduced administrative costs: they no longer need to direct-bill patients, to verify coverage or to comply with the paperwork required by a number of insurers.

The provincial governments have considerable power to limit increases in the costs of health services:

- The majority of hospitals are non-profit, owned and operated by voluntary agencies, municipalities and other agencies. A hospital's operating costs must be paid for out of the annual global budget it negotiates with the provincial ministry of health. While political pressures may cause the province to pick up the deficit of a hospital unwilling or unable to stay within its budget, the process nonetheless tends to dampen budget increases.
- A hospital's capital expenditures (e.g., on new facilities, major renovations or new equipment) also must be approved by the province, which is usually a major source of capital. The province may refuse to pay the operating costs of facilities or equipment acquired without its approval, even if the acquisition was privately financed.
- Any increase in a health plan's payment for doctors' services is set by negotiations between the province or territory and the organization representing medical practitioners; in most cases, the provincial medical association decides how the increase will be divided among the medical specialties.

Criticism and Response

Critics of Canada's program charge that built-in contradictions in policy put the system under unsustainable stress: it is impossible to give everyone comprehensive public health insurance, have government control its budget and leave doctors and hospitals free to decide what services they will provide, and how. Critics find signs of system breakdown: patients suffer long waits before hospitalization for "non-urgent" care; hospitals suffer from overcrowding, under-staffing and outmoded equipment and facilities; doctors suffer loss of both professional autonomy and income.

Defenders of the system argue that the waits for hospitalization are not so long as to cause a problem in health care delivery. Patients generally wait one to three months for elective heart surgery, for example; on occasion, the waiting period has exceeded four months. When problems have arisen, the government has added to the hospitals' resources.

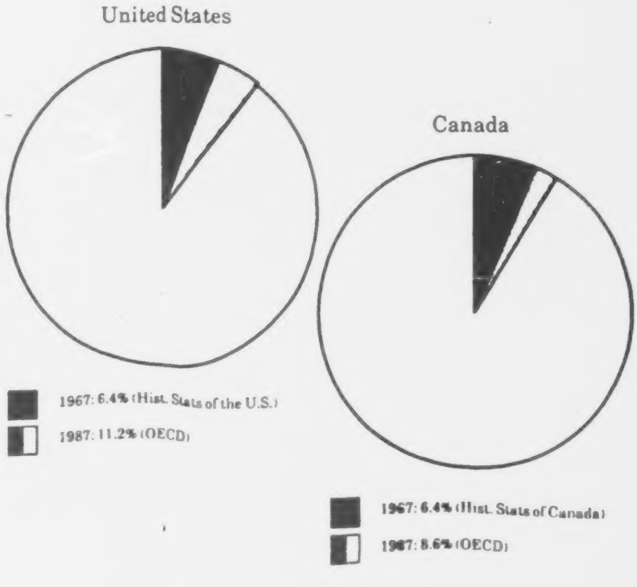
In Canada, expensive high-tech equipment is distributed among a city's hospitals to avoid unnecessary duplication of services. Budget restraints force hospitals to get the maximum use out of a hospital's buildings and physical plants. Cost-control processes do tend to delay the introduction of some new technology until the effectiveness has been adequately assessed.

There is no doubt that doctors earn less than the market would bear if it were fragmented into those who can pay and those who cannot. The average gross income of Canadian doctors in 1986 was U.S. $110,100. Incomes vary greatly by province. For example, the 1986 average in Quebec was $88,600; in Alberta, $99,600; in Nova Scotia, $105,600; and in Ontario, $126,200.[3]

The Canadian health care system has been continually evolving since the first provincial hospital insurance plan was introduced in 1947 in Saskatchewan. Its evolution shows the system's ability to respond to internal stresses as they arise.

For more information on the Canadian health insurance program, please contact Health & Welfare Canada, Tunney's Pasture, Ottawa, Ontario, Canada K1A 0K9.

The Increasing Cost of Providing Health Care
As a percentage of GNP



Notes

[1] The Hospital Insurance and Diagnostic Services Act (1957) and the Medical Care Act (1966) set the original conditions for federal grants to provincial hospital insurance and medical care plans. The calculation of federal funding and the means of payment were later changed by the Amendments to the Medical Care Act (1976), the Federal-Provincial Fiscal Arrangements and Established Program Financing Act (1977), and Bill C-97, which was passed in 1982 and which amended the EPF Act of 1977. The 1984 Canada Health Act entrenched the basic principles underlying the national health insurance program.

[2] Inglehart, J.K., "Canada's Health Care System," *New England Journal of Medicine*, 1986; 315:202.

[3] Estimates from Revenue Canada.

Canadian Embassy / Ambassade du Canada
501 Pennsylvania Avenue, N.W., Washington, D.C. 20001. Tel: (202) 682-1740

Mr. ROYBAL. Thank you very much. The Chair now recognizes our final witness, who is here today in her capacity as Chair of the Advisory Council on Social Security, Department of Health and Human Services.

In 1988, Ms. Steelman served as the Chief Domestic Policy Advisor to President Bush during his Presidential campaign. The young lady is very knowledgeable. I'd like to welcome you, Ms. Steelman, and ask you to proceed in any manner that you may desire.

STATEMENT OF DEBORAH STEELMAN, CHAIR, ADVISORY COUNCIL ON SOCIAL SECURITY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. STEELMAN. Thank you very much, Mr. Chairman. It is certainly an honor to be here this morning, particularly to be here with my neighbor, Congressman Bilbray. Good morning.

It is an honor to appear with these witnesses who you have very correctly described as experts. I would not put myself in that category. In 1985, I began work at the Office of Management and Budget, trying to learn and make sense of the Medicare and Medicaid programs. I am still very much trying to make sense of those programs, so I would not call myself an expert.

I was very thrilled when the President and the Secretary asked me to chair the Advisory Council on Social Security, because I believe those programs make up the fundamental cornerstones of our government programs, and that we very much need to apply the same scrutiny to those programs that my fellow witnesses have suggested that we apply to the health care system as a whole.

The Advisory Council on Social Security has been working since 1937. About every 4 to 6 years it has been appointed by the President in office. It has a very solid track record for its recommendations being enacted into law within about 2 to 10 years after they were made.

All of the members of the Advisory Council take their work very seriously because of this track record. The Secretary sought to make sure that the membership of the Advisory Council was very balanced in a number of respects. Not only philosophically and politically, but geographically, among the different expertises that are represented on the Council, and very importantly, generationally.

We have two members from each decade ages 30's through 70's. As we face the problems of health care and retirement policy over the next decades, that will become a very important issue.

I am very fortunate to serve on the Council with other esteemed members that are very familiar to this Committee—Chairman Bob Ball, the former Chairman of the Social Security in the Nixon administration; Jim Jones, one of your former colleagues and Chairman of the Budget Committee; John Dunlop, former Secretary of Labor; Paul O'Neill, former Deputy of OMB and currently the CEO of ALCOA; and eight other individuals who are just as esteemed.

We hope very much that by bringing these expertises and these various constituencies together in one room, that we will come out with recommendations that can make sense not only to both political parties, but to the constituencies that these people represent.

Our mandate is to study both retirement and health issues. We will try to issue our final draft report on the health issues in July 1990, and we'll try to issue our report on retirement in December 1990.

On the health issues, per se, since those are the ones of key interest to this Committee, I'd like to describe our charter with a little detail. We have been asked to review Medicare and Medicaid and to describe whether or not a funding of those programs and the coverage provided by those programs are adequate to meet the needs of the people over the next 5 to 50 years.

That is a very long time frame, and we are trying to set out the big picture of where these programs need to go. In accomplishing that mandate, we recognized very early that we could not do so without looking at the other types of health care coverage that are available in the country through the private sector.

So, we have broadened our scope to include the entire health care financing system, recognizing that a review of Medicare and Medicaid, without going to the problems caused elsewhere, would not be relevant to the bigger debate.

You have asked us to address the essential elements of the health care problem and what might be a solution. Certainly, I couldn't add anything to the problems that have already been expressed by my fellow witnesses, and I don't think I would disagree in any substantial way with any of their presentations.

I would simply like to stress these issues. First and foremost, we need to put some common sense into our health care financing system. One of the reasons that we have a great difficulty creating a critical massive support for any given idea, is that so many ideas seem to be estopped from political debate.

Of course, this is one of the frustrations that anyone involved in campaigns, as I was with the Bush campaign, comes to grip with very quickly. That it is very difficult to discuss this issue in a political context. Both parties are very successful at demagoguing each other on the issue, and we can no longer afford to take that road.

The problems are simply too big and too serious to either rely on our past investments in any given set of ideas, whether they were enacted in the 30's or the 60's, or just last year. But to really come to grips with putting some common sense—not only into the Medicare and Medicaid programs, but into our entire health care financing structure.

In that context, I think the first rule is we've got to simplify this thing. Beneficiaries cannot understand these programs. I, as a lawyer, have been trying to take these programs apart for the last 4 years and try to understand why certain things have evolved and what they are.

The very laudable goals of the Medicare and Medicaid programs to go into a marketplace where private insurance has not worked, to go into the poverty population and provide good care, to go into the high risk senior population and provide good care—those simple, laudable, common sense goals are no longer being addressed in many ways by those programs.

Not only in Medicare—an easy example is why does it depend on the type of illness you have as to whether or not you have coverage? If you have Alzheimer's you have no coverage. If you have cancer, you do. This really makes no sense, and we have got to start addressing those basic ideas.

The second item, aside from simplicity, that I think still comes along in the common sense framework, is comprehensiveness. Catastrophic—I think we are going to learn the lessons from that bill for a long, long time, but there are several lessons that I think, at least now, are safe to say we have learned. That is, as one of the former witnesses has stated, comprehensiveness is the key to reform here.

A patchwork, either in terms of financing or in terms of coverage, is not going to work. We've got to take a look at the financing we've got out there and the coverage, and try to make some comprehensive changes. That is true in terms of eligibility, in terms of coverage, in terms of financing.

I'd also like to stress quality as several of my colleagues have done, but I would like to, perhaps, disagree with where they think the best quality could be obtained. Clearly, the Federal Government's role in research, in effectiveness research, in outcomes research, in working with the specialty societies and the medical profession to help develop protocols, is critical.

I would support, and I believe every member of the Council would support, additional research funding for that. Anyone who thinks that simply making a national program will in and of itself be a good quality program, only needs to take a look at the programs we have on the books.

Anyone who has experience with the Medicare and Medicaid programs, knows what has happened when providers feel squeezed by government, knows what happens to the quality of service when we make decisions that are not based on health policy but are based on budget policy.

Anyone whose doctor has come to them and said, "Medicare is kicking you out. Here is your pink slip today", knows that this is not, by any means, a perfect program. We have to come to grips with the changes in the Medicare and the Medicaid programs that are necessary, along with the other changes that have been suggested today.

Lastly, I'd like to mention financing which, of course, is the sticky wicket that everyone says after they give this wonderful, great notion of how to improve the system, they say with a wink, of course, we've got to come up with the financing.

Certainly, Mr. Chairman, your bill has addressed many of the elements I have suggested here—comprehensiveness, some common sense, but the financing mechanism in your bill is extremely complicated and hits a number of very powerful constituencies.

I would hate that our drive for comprehensive health care reform would be ripped to pieces on the shoals of the fight over financing mechanisms. In that context, I would like to say that the Federal Government already spends $200 billion on health care. In a $600 billion agency, one-third of those funds come from the Federal Government.

Certainly, we can do, in the Federal Government, a great deal more with our expenditures, whether they are in the CHAMPUS program, the VA program, the Medicaid program, the Medicare program, or the Tax Code.

We have an awful lot of money that we need to take a serious look at before we—as I mentioned earlier, perhaps wreck the necessary health care reform on the shoals of very politically difficult financing propositions.

Catastrophic, I think, here again, proved some valuable lessons. One of the things that you can learn or you can possibly interpret from catastrophic is that people are more comfortable with premiums than they are with taxes, at least in certain circumstances.

We have a huge private insurance mechanism in this country, and I am not saying it is perfect either. But we need to come to grips with, perhaps, some more common sense approach to the linkages with the private sector and the premiums, and our public programs and the taxes and perhaps, give those separate distinctive domains.

I'll try to give you a little bit better feel of what I mean by this in a minute. There are a couple of things that any comprehensive approach must review, I think. Number one is a cardinal rule, really, that financing drives delivery. What is covered by the financing mechanism is delivered, and it is delivered in the way that financing calls for it.

This is one reason we have an enormous industry in the hospital industry, and we have very little industry in the home care industry. We must spread out our financing mechanisms to vary provider settings, so that we can have the services available to people.

The point I have already mentioned about the relationship between premiums and taxes and to try to take advantage of the strengths of both of those systems.

Thirdly, that the market out there we have in health care was structured by the Federal Government. We call it a private market because in America that is the way we are accustomed to looking at this thing. We have a huge private sector industry. It was pretty much created by the Federal Government.

The tax exclusion in our post-World War II policies that caused the enormous growth of private insurance are pretty much on the books today. Any market that the Federal Government created, even if it is a private market, the Federal Government can change.

I would urge the Committee to take into account the full $200 billion, Medicare, Medicaid, Tax Code, and really take a look at restructuring those funds as well.

Lastly, I'd like to say that any reform which, as we have already noted this morning is so critically needed, acknowledge the future. Our future will be very different than our past. The next 25 to 50 years will look very different than the last 25 to 50 years, not only the demographics that I'm sure all of us can recite by heart anymore, but our family dispersement patterns, our work force, our children.

We have to invest in this country's future. Right now, as it has already been mentioned, we have 11 million children without health care in this country. Those are the children who will be the economy of the 2020's, when certainly many people my age and older will be in retirement years. That is a population that requires investment, and we really need to look at it.

I would like to close by giving the first elements of the plans that the Advisory Council has under consideration. We have had two meetings. At our last meeting, we focused on the retiree population. At our next meeting, we hope to focus on the working age population.

We laid out a plan that the staff will be developing and modeling over the next few months, so I would urge you that this plan is not at all as clear cut as many of my colleagues who have worked on their plans for several years.

It is a plan that hopes to come to grips with some of the health policy goals, some of the demographic changes and economic changes in our country, and some of the basic expectations and common sense desires for our health care system.

Essentially what we put before the Council for its further review, and I would like to stress that this plan does not constitute the precise views of any member of the Council, was a restructuring of the Medicare program which would broaden its reach, which would eliminate the rather arbitrary determinations in the program that provide financing only on provider setting, whether or not you happen to need certain services, not in a long term home care institutional setting.

We'd like to broaden the reach of Medicare to include the five basic benefits; in-patient, out-patient, pharmaceutical, home care, and long term care, so that you can be managed into the most appropriate setting, as well as the most cost effective setting.

We'd like to focus Medicare on catastrophic costs. Say, that there would be a limit on lifetime costs after you have reached the age of 65-some manageable limit.

We would also like to expand the reach of private insurance. Right now, private insurance in the retiree market is pretty much limited to Medigap and to long term care policies that are just now in their beginning stages, and are certainly improving with time, but are very difficult to sell, and very hard to buy.

We'd like to expand. Instead of having those separate features in the private market, we'd like to expand the private market to mirror image the public market, and to require any organization, insurer, or otherwise, who is selling products to the retiree market, to cover those exact same benefits; in-patient, out-patient, pharmaceutical, home care and long term care, focus that program on the more moderate costs under the catastrophic threshold.

We would hope that at least in the first year, this kind of a system could be budget neutral and, therefore, be enactable in this day and age of budget constraints.

We would hope that by combining the private market resources and people's personal resources and employer/retiree resources, we would be able to have a program that would adapt to the demographic changes we face.

The third element, aside from the expansion of both the private and public sector responsibilities, and dividing those responsibilities into distinct financial domains, we would like to subsidize the cost of the private insurance portion of it, so that no one would be left out by inability to pay, but that they would be able to get the exact same level and quality of care as anyone else in this country.

Anyone who has spent down into Medicaid and has to depend on Medicaid to provide their long term care protection as opposed to a private paid policy, knows the distinctions between a purely funded program and one where, perhaps, we would allow everyone to buy into the same quality of care.

So, the third idea would be that we would subsidize these programs—the purchase of the private insurance or, let's say, 95 percent subsidy for anybody below the poverty line or, perhaps, 100 percent subsidy, phasing out at 200 percent of the poverty line. That's the third idea.

The fourth step would be to figure out some way to reward cost effective plans. This is a notion that many of my fellow witnesses have suggested, that we reward managed care, that we reward plans where the most cost effective behavior is ascertained.

Many people think that the Federal Government has been much better at cost containment than anyone in the private sector. But we have resorted to tactics in the Federal Government that aren't available to the private sector. We simply refuse to pay bills. We default on our bills. We underreimburse. We shift costs. We deny coverage. That is not available to the private sector and, consequently, they have had to make up for our "cost containment".

We don't think this should be an appropriate mechanism—that the Federal Government should have to live by the rules everybody else, and that's appropriate reimbursement and finding ways to make sure cost effective plans are the rule, not the exception.

Lastly, the fifth point, is to make this kind of program completely optional—completely optional to seniors. Many seniors have good retiree coverage that could be very easily reworked to fill the front end, to fill the below the catastrophic limit, so that they would not have any difficulty.

Many seniors would be able to find a group package through AARP. They already sell a great deal of insurance. Group coverage would not be difficult to find or purchase, but change is a difficult thing for us, as we have noticed over the last hundred years in health care policy. We have had national health insurance. We have had major reforms about every 15 to 20 years since the 1870's. This is not a new topic. Change is very difficult.

Let's make this kind of program entirely optional. If a senior would rather have Medicare, would rather have Medigap, would rather continue to pay private pay for some things, would rather have long term care as a part of Medicaid, certainly that should be their option, or at least an extended phase-in period.

If they would rather have a private policy for the first part of their coverage and a public policy for the last part of their coverage, in exchange for a comprehensive proposal, that should be their option. That should be something we give them.

One of the reasons the Canadian model is so very popular in that country, though I will certainly defer to my colleague, is that it eliminates fear. In health care in this country, we are a fearful population.

That's one of the reasons that it shows up in Mr. Beldon's poll as something 89 percent of us would choose to change, but I wager does not show up in any of your polls when you try to decide how you're going to get your 51 percent of the vote. There are a lot of things that show up before health care financing.

Any of the Democrat or Republican polls I have looked at, health care financing is lucky that it appears at all, unless prompted.

Even if prompted, shows up below 10. Age shows up high. Drug abuse shows up high. Health care financing does not.

We are fearful but, for the most part, many of our people are very fortunate to have full health care coverage, and think that the risk of tax increase, and the risk of government intervention, is too much—that they'd rather keep what they have. What we owe them, as well as those who are not covered, is a policy that does remove that fear—a policy that says, I can control my future and my government will offer me a comprehensive option.

Thank you very much. I'll be happy to take any questions.

[The prepared statement and supplemental material submitted by Ms. Steelman follows.]

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STATEMENT

OF

DEBORAH STEELMAN

CHAIR

ADVISORY COUNCIL ON SOCIAL SECURITY

SELECT COMMITTEE ON AGING

U.S. HOUSE OF REPRESENTATIVES

November 9, 1989

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Statement of Deborah Steelman
Chair, Advisory Council on Social Security
Select Committee on Aging
U.S. House of Representatives
November 9, 1989

Thank you, Mr. Chairman, for inviting me to testify this morning about the work of the Advisory Council on Social Security. As you know, the Social Security Act requires that an Advisory Council be appointed every four years to review the programs authorized by the Act. The Social Security Act specifies that each Advisory Council will review the long range financing of the Social Security and Medicare programs, and the impact of these programs on public assistance programs authorized by the Act.

This year, Secretary Sullivan asked the Council to focus its efforts in two important areas: 1) the issues surrounding the OASDI Trust Fund surplus and the future demands on the Social Security cash benefit programs as a part of overall retirement policy; and 2) the adequacy of the Medicare and Medicaid programs to meet the health and long term care needs of all our citizens. Since your concern today centers on reforms in health care financing, I will concentrate my comments on our efforts in that area. But, before I discuss our substantive work, let me give you some general information about the Council.

THE ADVISORY COUNCIL

Since 1937, advisory councils have been assembled to provide expert advice to policy makers on Social Security Act programs. As in the past, the current Council is made up of a cross-section of experts and interested citizens. The members of the Council bring not only their expertise but also their sincere commitment to the tasks of examining carefully our health and Social Security programs and recommending ways to ensure their continued viability.

The Council is bipartisan, geographically diverse, and it represents Americans of different generations. Council members represent employees and employers, health care providers and suppliers, academic experts and the public. The Council includes several former government officials whose previous responsibilities involved overseeing our national employee benefit, health and retirement programs and advising the Congress about these programs. These individuals thus bring direct operational and policy expertise to the Council. For your information, I have appended to my testimony a list of Council members.

The Council has scheduled 10 meetings in 1989 and 1990, and is charged with completing a final report to the Secretary of Health and Human Services in January, 1991. All of our meetings are open to the public, and we will seek wide public comment on our work throughout the process, particularly through circulation of draft recommendations for review. We are working closely with the Pepper Commission at the staff level, and that collaboration has enabled us to move forward quickly on the difficult issues we have been assigned. We expect to continue our close working relationship with the Pepper Commission.

We began our intensive review of health care issues in August, and currently plan to release a draft health report in July, 1990. A final draft report on Social Security and retirement issues is planned for December, 1990. Both drafts will be revised and included in the final report to the Secretary of Health and Human Services. As specified in the Social Security Act, the report is then transmitted to the Congress and to the Board of Trustees of the Old-Age, Survivors, Disability and Health Insurance programs.

HEALTH CARE FINANCING REFORM

You have asked me to address the problems of health care financing today, but you are already more expert at this than I. This Committee has played an important role in raising our national awareness about the many inadequacies of our financing system - millions of people without coverage, the complexity of our public programs, the inferior reach of Medicaid to help our poor, the lower health status of our minority citizens, the immense cost of our system while producing results that compare poorly with other nations' smaller investments. There are too many people who have groped without success for acceptable health care coverage. This is truly unthinkable -- unbelievable -- in a nation of our wealth and compassion.

The government and the private sector interact, overlap, duplicate and omit financing for many services and people who need health care today. The meandering path of health care financing in this nation for the last 100 years grows more complicated and less satisfactory every day. Many of you have watched us wander this path during your years in Congress; you have struggled to put common sense into our laws and regulations. Health care is one of our most complex public policy issues; many times we have had to settle for an incremental solution when we knew much more was needed. And so you fought for an inch or two when you knew we needed miles.

Instead of the compassionate and cost-effective system we wanted, we have a dysfunctional health care market characterized by great inequities and cost escalation, where the public/private partnership is instead a public/private cost-shift war. And in the process of fighting this war, many constituencies --

providers, financers, beneficiaries -- have become invested in the status quo, to the virtual defiance of personal and societal goals and needs.

The magnitude of this dysfunction presents both the opportunity and the challenge to think beyond our current programs and policies -- to consider systemic reform. Marginal change cannot solve problems of access, quality, and cost in American health care in any meaningful way. I believe that most of the Council members share this conviction. Thus we are committed to think broadly, to investigate significant and fundamental change, and to focus on both the current and future needs of our citizens as beneficiaries and taxpayers.

At the Council's first two meetings, we examined the demographics that will radically alter the numbers and mix of citizens who will need health care and income security support in the future. We also reviewed current Federal programs and discussed their accomplishments and shortcomings. We noted that systems that have worked reasonably well in the past may require significant change if we are to meet the challenge posed by the Nation's growing health and long-term care needs when the baby boom enters retirement early in the next century. We discussed the principles that we believe should be present in the American health care system, and drafted a statement of principle. We have circulated this draft widely and have received comments from many interested parties. This draft statement of principle is also appended for your consideration.

REFORM OF PROGRAMS FOR THE ELDERLY

At its October meeting, I presented the outline of a plan for reforming health care financing programs for the elderly. The Advisory Council staff has developed a more detailed description of this plan for the Council members' review before our December meeting. I would like to briefly describe the goals, working assumptions and key elements of this strategy for reforming health care financing programs for the elderly. This plan is intended to serve as a catalyst for the Council's deliberations. The Council has not debated this plan in detail, nor have members formally agreed to it either in general or with regard to any of its specific features.

In my view, a successful reform plan must address several key problems. These include:

- Many gaps exist in current coverage. While many elders have no coverage for important portions of their health and long term care needs, others have policies or coverage that is duplicative.

- There is fragmented and biased financing and service delivery. Seniors' health care needs are financed and served in a disjointed manner, often emphasizing the provision of institutional rather than the home or community based services that they prefer.

- Current programs are extremely complex, with burdensome paper work for the elderly. Notices and bills from carriers, intermediaries, providers, various insurers and government agencies may accompany a simple visit to a physician or laboratory. We should be able to design a common-sense system that all can understand, reducing or eliminating the barrage of paper-work now involved.

- Escalating costs to beneficiaries, the government, and providers must be controlled. Our current system shifts costs rather than controls them. Beneficiary out-of-pocket costs should be more predictable and controllable. Government policy is and will continue to be so driven by budget concerns that it is not and cannot be the only solution to our health financing problems.

I suggest that our goals in redesigning financing for the elderly should include comprehensive service coverage, limited personal liability, simplification, universal coverage, and better management of cost and care. Public and private funding should be coordinated, consistent with these goals.

Debate and refinement of our working assumptions is critical to consensus on reform solutions. The Council discussed working assumptions extensively at our October meeting, and that discussion will undoubtedly continue. I believe that the following assumptions are useful:

- Explicit rationing is unacceptable in the United States.
- Piecemeal reform is insufficient, and comprehensive reform should be sought.
- The federal share of financing for health care (that is, the proportion of expenditures borne by the federal government) will remain at or about its current level, neither substantially increased or decreased.
- All of those currently involved in health care financing in this country -- the government, employers, employees, unions, insurers, providers, and consumers -- will retain a significant, even if different, role in a reformed system.

This reform plan, which was devised as a catalyst from which the Council can work, flows from the key problems, goals, and working assumptions described above. Key elements of this plan include the following:

- o Expand social insurance to cover long term care and
- o Focus social insurance on high cost users

- o Expand private insurance to cover a full range of services and
- o Limit personal liability

- o Subsidize premiums for the poor

- o Reward cost-effective plans

As I noted, the Council staff has developed a preliminary draft of this plan, which has just been sent to Council members for their review and comment. I would be pleased to provide the Committee with a copy of this draft in the same spirit: it is intended as a catalyst for discussion among analysts and health policy makers.

In December, the Council will begin its discussion of Social Security issues and continue its discussion of this health financing plan for the elderly. In addition, we will begin discussion of problems, goals, assumptions and strategies for dealing with reform for addressing the needs of non-elderly population. We expect that the principles used in designing reform for the elderly can be applied in designing reforms system-wide, ensuring that everyone in this country has access to necessary health care services.

CONCLUSION

This nation has a window of opportunity to examine alternatives and develop major reform strategies, particularly for the way we finance health care. This window will narrow as health care costs continue to rise out of control and as the needs of an aging population force crisis decisions, even in the next decade.

The Advisory Council will, as I have indicated, consider systemic restructuring and replacement of existing programs. We will consider new programs and policies if they promise greater success in closing the many gaps in access and financing we have now, and ensuring a continuum of needed health and medical care services for preventive, acute, chronic, and long term care. We are considering every option -- no matter how unconventional. We are trying to stretch the ways we have all come to think about health care financing and delivery in this country.

We of the Advisory Council believe our job is to push ourselves to see and understand the health care and income security implications of the next five to fifty years, and to help begin the process of thinking anew. We hope to help create the new approaches that the future demands. We demand from ourselves creativity, imagination and vision. I believe that this is our opportunity and our duty.

We look forward to working with you and the growing number of others committed to major health care financing reform. I would be pleased to answer any questions you or members of the Committee may have, Mr. Chairman.

Draft Statement of Principle
Advisory Council on Social Security

All people should be able to obtain necessary health care. All citizens share the cost of health care; these costs should be distributed fairly and consistently with the nation's long term well-being. Individuals, employers, and government should have a role in paying for health care. Methods of health care delivery and financing should constrain growth in health care expenditures commensurate with improvements in the value of health care. Health care services should provide the most effective treatment in the most cost-efficient and compassionate way.

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Response from Deborah Steelman to Questions from Chairman Roybal
November 9, 1989 Hearing
House Select Committee on Aging

1. In your role as close advisor to President Bush, will you be encouraging him to take a stronger interest in joining the Congress to bring about comprehensive health care reform?

   As you know, Mr. Chairman, the Advisory Council on Social Security is formed every four years by law to advise the Secretary of Health and Human Services on matters related to Social Security programs, including Medicare and Medicaid. As Council chair, I have encouraged, and will continue to encourage the Council to consider comprehensive reform of health care financing.

2. Given your testimony, can I assume that you are ready to work closely with the Committee on comprehensive reform, including ensuring insurance coverage for all Americans, both elderly and nonelderly?

   Mr. Chairman, I share your conviction that all Americans must have adequate access to our health care system. I am honored to work with you toward this goal.

3. On the issue of financing, please review the financing plan for my USHealth legislation and give me your opinions on that financing package. Also, please detail what financing sources you believe to be the best choices for financing health and long term care in this country and approximately what portions of this care should be financed by each source.

   Mr. Chairman, I personally believe that long term care in this country, particularly for our elderly population, should be financed in a comprehensive strategy that recognizes and encourages the management of a continuum of care for patients' acute and long term care needs. The current fragmentation of acute and long-term care financing in both public programs and private insurance plans leads to fragmented service delivery and excessive complexity for the elderly and their families, as well as for health care providers.

   Our system of financing health care currently involves individuals, employers, government and providers. I believe that any feasible system of health care financing in this country should continue to rely on each of these sources for financing. However, I also believe that their current roles may not be the most efficient. The Advisory Council is committed to examining system reforms that restructure the roles of private and public financing for the elderly and the nonelderly populations, in an attempt to find a more efficient

mix.

4. Isn't your elderly package with its restructuring of Medicare raising an issue that Congress and recent administrations have rejected, namely "means testing" in Medicare? Also, please clarify how lower income, not just the poor, can afford adequate coverage.

The Advisory Council staff proposal under discussion by the Council would not means test benefits. All enrollees would have access to the same plan benefits and the same social insurance protection. The Social Security Act already recognizes that low-income elderly require additional assistance; this principal is embodied in the Medicaid and SSI programs. Accordingly, low-income elderly would receive a subsidy to purchase insurance coverage. My personal opinion is that the assistance offered by Medicaid and SSI is too low.

5. On basic access, do you agree that comprehensive reform needs to ensure insurance coverage to all Americans, especially poor and near-poor Americans, whether they are working or not?

Mr. Chairman, I agree.

6. On quality, do you agree that publicly-accountable quality assurance, like Medicare's peer review organizations and federal and state nursing home and hospital regulation, should apply to all patients and providers, regardless of who pays?

Quality assurance is a critical element of any reform of the nation's health care financing system. While the programs and processes for quality assurance in a reformed system would in part depend on the nature of the reform and the structure of new financing and delivery systems, there are some elements of existing programs that would undoubtedly transfer. The Institute of Medicine will release in early 1990 a major report and recommendations for assuring quality of care in Medicare. The Council will consider this report seriously in making its recommendations for reform of our nation's health care financing systems.

In addition, I strongly support continued research on the cost-effectiveness of specific types of care, and on the cost-effectiveness and quality of care provided by gatekeeper or managed care systems. If public monies are to be spent responsibly, I believe that public subsidies should target enrollment in proven, cost-effective health care arrangements.

7. On services, do you agree that both long term care and acute

medical care need to be covered services for elderly and nonelderly Americans?

I agree, Mr. Chairman, that integrated financing of acute and long term care is necessary to ensure appropriate service delivery. Discussions with long term care experts, however, have raised concerns about the tractability of financing social long-term care services (versus medical long-term care services) outside of a fully managed care setting. We need to consider funding for social long-term care services that encourages appropriate development and subsidization of community-based social services, especially for middle- and low-income consumers.

8. On costs, do you generally agree that health costs need to be limited to 12 or 13 percent of GNP (or grow close to the rate of growth of GNP), payments should be prospectively set and indexed, and patient out-of-pocket liability limited?

Mr. Chairman, at this time, I do not believe that federal regulation of total health care spending, specifically the global budgeting that you suggest, is the only solution for controlling health care costs in this country. This nation faces dramatic demographic changes over the next 30 years. Consequently, appropriate health care spending may be higher in the next century than it is today. We need a system that encourages efficient spending for health care. I would prefer a financing system that strongly encourages efficient service use and enables meaningful price negotiation to a system that relies on arbitrary spending limits.

Mr. **Roybal**. Thank you, Ms. Steelman. It is usually the general procedure that the Chairman starts off the questioning for 5 minutes, and each member of the Committee then has 5 minutes to question the witnesses.

I'm going to change that somewhat, because I did not have the opportunity of introducing members of the Committee that came in after the witnesses started their testimony. I will, therefore, ask Mr. James to proceed for 5 minutes, and he has already been granted unanimous consent that his opening testimony be included in the record.

At this point, he may now use the 5 minutes in any way that he may desire. Please proceed, Mr. James.

Mr. **James**. Thank you very much. I just have a few questions of Ms. Steelman. The catastrophic effort last year mixed the concept of taxation with premium. Was that not a fair statement to some extent?

Ms. **Steelman**. I think that many of us in Washington thought those concepts were mixed. People clearly saw through that. They saw it as a tax.

Mr. **James**. Yes, some people even referred to it as a catastrophic income tax if they were paying the $1,600.

Ms. **Steelman**. That's correct.

Mr. **James**. Yes. Okay. Now, was it not obvious to most people involved that they would get some very negative reaction for people that were paying $1,600? That when, in fact, they were either a Federal employee or had a private insurance program, so, therefore, they wouldn't benefit at all?

Ms. **Steelman**. My personal view is that too much of the opposition has been based on people who have already been covered, or people who were wealthy opposing the bill. Certainly, that was the case, but I would like to make a suggestion. My personal observation is that what is impossible to evaluate is impossible to value.

In a catastrophic program where you already have Medicare Part A, Medicare Part B, private pay for uncovered sources, Medigap premiums that still go up even if you don't use it, spend down in the long term care, I still have uncovered expenses.

It was impossible to evaluate the catastrophic benefit in the context of Medicare and retiree benefits. Consequently, it was impossible to value.

Actuarially, even the high cost beneficiaries, even the people who would have been paying jointly at $1,600, were still getting a very good deal out of Medicare in context—a very good deal. But it is impossible to value what you cannot evaluate. And that was clearly, I think, the Achilles heel of that legislation.

Mr. **James**. You mean, you think that—excuse me, I don't understand. The person paying $1,600 clearly did not get his benefits out of it because that $1,600 was funding the people who didn't pay at all. So, I don't know how you could submit that as a—

Ms. **Steelman**. Well, because as I mentioned, in the context of Medicare, if you look at the whole program, what that couple paid was a good value. If you look at only those benefits and what they paid, which they weren't given that option because it wasn't an optional program, then it was not valuable.

Mr. **James**. Okay.

Ms. STEELMAN. Does that help?

Mr. JAMES. No. Yes, it does, but my understanding of the program, and correct me if I'm wrong, it was revenue—in fact, it was a $5 billion—it's first estimate was that you would have $5 billion surplus, simply from those premiums even after paying all of the benefits required for that class of people in the first year. Then, it dropped to $3 billion.

So, obviously, the person paying $1,600, or the couple paying $1,600, hardly received in benefits anything close to that. Their premium, if prorated out, would have dropped down to $200 or $300 at most.

It is my understanding of the mathematics of it—in other words, you have got one pie. You divide it up, pay out all of the benefits, you still had $5 billion left over, so it would be impossible to say that the person paying $1,600 got anywhere near that in benefit returns.

That is a mathematic postulate that is difficult to argue with, since the pie is only so large, would you not say?

Ms. STEELMAN. There is no question that it is hard to make a common sense approach from that, but I would suggest that any insurance policy needs to have a reserve. We require that of private insurance policies and public insurance policies. The fact that you are covered is the benefit, not the fact that you may or may not get sick.

Mr. JAMES. Okay. Thank you. I understand that, but you—but the people that did pay the higher premiums, no one ever argued they received the benefits. I have never heard that argument made except here, and I don't mean to argue with you. I have appreciated your testimony a great deal. I didn't expect that reaction.

Having had that kind of—where do we go from here, now, because the benefits we all admit are needed is the problem that we have after that exposure to that problem?

I heard testimony that it costs $5,000 per year per employee from one of the statements. I think it was Mr. Fraser. Now, how do we fund that is the big question. What would you suggest in the manner that we fund it?

Ms. STEELMAN. Several things I said in the testimony—that we need to use premiums and taxes to meet people's expectations, recognizing perhaps distinct domains of both of those. The formulation that we laid out in the Advisory Council, which would separate those in the distinct domains and allow an increase of benefits in exchange for a Federal Government covering a catastrophic only, was our way of trying to make that a budget neutral proposition.

Mr. JAMES. Okay. One of the big problems that the private sector has is you have small businesses and medium-sized businesses funding their insurance programs when the government is setting certain standards.

As you pointed out in your testimony, you are saying in your standards we will only pay so much for X procedures. Whereas, the private companies, as you said, do not have the ability to say, no, we won't pay.

So, does anyone in the panel know how much that affects in an upward fashion the premiums that are paid by the private sector? What I'm getting at is when I—before I came to Congress, I paid premiums for my employees. It occurred to me that when I got a bill from a hospital, or my clients got bills for their injuries, that you paid 100 percent. If they were on Medicare, Medicaid, they paid 40 to 50 percent, depending on the procedure. The same thing with hospital bills.

So, the private sector was paying $2 for $1 for the same services, that if you were over 65, and the government was paying it, it would be half as much. Are there any studies available that would show precisely how much the private sector is subsidizing the public sector in regard to the retirees? Do you know of any studies on that?

Ms. STEELMAN. The estimates are very hard to come by. I can't quote you which study this is, but estimates range from $18 billion to $30 billion. I'll try to provide the precise source of that.

Mr. ROYBAL. Time, Mr. James.

Mr. JAMES. Thank you very much.

Mr. ROYBAL. The Chair recognizes Mr. DeFazio.

Mr. JAMES. I want to thank you so much for your testimony.

Mr. DEFAZIO. Thank you, Mr. Chairman. I'd just like to reflect on what the varying testimony we heard—seems to me there are some very common threads. I think, perhaps, in this country we have reached the point where we have a unique opportunity to form a coalition that will finally bring us to a more rational and universal system of health insurance and provision of health care in this country.

My hospitals are in regularly to see me, particularly my rural hospitals. They are going broke. The physician is not particularly happy with the paperwork and/or the reimbursement system of Medicare. As we have shown in the polling, and certainly what I have from my constituents, the consumers, they are not overly thrilled with the current system, let alone the ones who have no access to health care until they have an emergency situation.

My local governments are groaning under the burden of insuring their employees, much as business is, as Mr. Fraser pointed out. And the Federal Government is concerned about costs and attempting in some very blunt and, I think, indiscriminate ways to restrict the reimbursement of health care, particularly through the reconciliation process.

So, it sounds like we have got quite a huge and diverse group of interests out there that would request strongly of our leaders, us, hopefully, that we go forward. The question is, how? What is the vehicle? How are we going to bring together this rather, I think, unique set of—many of these groups were opposed to the original enactment of Medicare and/or at the time, particularly dubious.

So, we have had catastrophic. I was one of the Members of the House who voted against it, not because I don't believe we need major improvements, but because I thought it provided benefits we don't need at a cost people didn't want to pay, was an unfair financing system.

The question is, how do we make that step? I would ask from your expertise—I mean, what drove Canada to it? What would bring the Bush administration to making a proposal for a comprehensive health care system and highlighting it as a priority?

As a former Member of this body, what would you see would make this body act on this issue? How are we going to cross the Committee lines? How are we going to get action? Certainly, what is the role that the working people of American labor would play?

If anyone has a good idea of how, I would love to hear it. We're all here sort of green. We have slightly different solutions, but—

Mr. Roybal. The Chair will recognize anyone on the panel for a response. Mr. Rogers?

Mr. Rogers. Let me just begin by saying, you know, we thought it was going to be something when we enacted DRG's, controlling hospital costs, in-patient costs. The Congress took that step, and it really was not adversely received by the public. In fact, they liked that once it was established because it started to cut down costs in the in-patient area. No one was defeated because of that.

Also, the Congress froze doctors' salaries. Do you remember that? No one was defeated with that. So, the Congress has made that step, and I think you're going to find some of these other proposals are going to be easier because of that experience, in the public's receiving it.

Now, I do think that it has got to be a private sector-government partnership. I don't think we are ready to have, in this country, a government take over the whole health system.

We are now paying about 40 percent—the government itself—of the health care bill of the Nation. But the private sector is paying the rest. As has been pointed out, when we do the controlling on our side, often we shift the cost over to the private sector.

Now, you are finding—Mr. Fraser said—not only is labor concerned, but industry is concerned. That is what happened that brought the culminating point in the DRG's.

I think you will find that by bringing a partnership, and we have gone into that in our plan, to move it, I think this can be done.

Mr. DeFazio. Just one reflection on this. My colleague's statement about the subsidization by the public sector—I would also reflect that the public sector picks up all of those groups that the private sector doesn't want.

We have a non-competitive industry in terms of a provision health insurance in this country, exempt from anti-trust law, and I would hope that the Bush administration will move on that issue. But we also have where we have the elderly, the disabled, and the poor, are publicly insured and now AIDS and other pre-existing conditions are being excluded by private policies.

So, on the one hand, my colleague might say, the private sector is subsidizing the public, I see the public as the dumping ground for all those that the private insurers would reject because they want to guarantee their profit.

Mr. Rogers. Some of that, of course, but the government has moved in to do that. We have established those programs. Now, as we begin to tighten down, we shift a lot of the costs over to the private sector as well.

Mr. Roybal. The gentleman's time has expired. The Chair recognizes Ms. Schneider.

Ms. Schneider. Thank you, Mr. Chairman. I regret, ladies and gentlemen, that I arrived here late. I had a conflicting hearing, so I missed the benefit of the wisdom that you shared with this panel this morning, so I choose to ask some questions that may not have been raised to this point because they are not at all, what you might say, conventional.

When I think about a comprehensive national health care policy, I don't think about some of the points that have been raised up to this point. Have any of you focused on prevention the underlying philosophy of a health care system?

Mr. FRASER. For many years, we have promoted—going back to the 50's, our organization promoted HMO's—Health Maintenance Organizations. We were one of the first in America, and we put, of course, tremendous emphasis on health prevention an health promotion.

I am currently involved in a foundation, Kaiser Family Foundation, where they have a huge program on health promotion and talk about dietary habits, non-smoking, adequate exercise, and they are also into a related subject of teenage pregnancy which bears upon the tremendous costs that we have to assume.

But I think any worthwhile program has to take into account to pay a great attention to health promotion because that is not only good for our citizens, but it will drive down the cost of the program.

Ms. SCHNEIDER. And it will clearly drive down the cost of disease because heart disease and cancer are listed as our Nation's top killers. Many of these diseases, we find, are very much related to the potential for us to prevent them.

Mr. FRASER. There are studies that show that people who do not have insurance, the 37 million without coverage, plus those that have inadequate insurance, they delay going to the doctor. At the point they go to the doctor, they are at a point of real emergency and urgency. Then, the costs escalate.

Ms. SCHNEIDER. Well, let me suggest to you a completely different proposal. This thought came about as a result of listening to my constituents. I have the largest senior citizen population per capita in the United States, after Florida.

My seniors, some of whom have saved a little money, were very upset about having to pay for friends and neighbors who couldn't afford health care costs. There are many people in my generation who jog, who eat good food, who take good care of their bodies, and they are very resentful about the prospect of having to foot the bill for those people who take drugs and have alcohol problems.

So, I think that there is a growing sentiment across this country that asks, "why do I have to pay for my neighbor?" If we step back and look at policy trends of the last several decades, we see this has happened in our welfare program. Yes, we all think it's wonderful to take care of our neighbor, but rather than give always, we want our neighbor to work and participate in helping himself.

The same is true with foreign aid. We want to help foreign countries, but we want to build sustainable development. We don't want giveaway programs.

I think the same kind of sentiment is coming about now with the health care program. People are saying that there is already so much abuse of the health care system: people are using the emergency rooms when they don't need them, people go to the doctors for a headache, et cetera.

It seems to me that we should begin with the premise that the Chinese have used: that prevention is the underlying philosophy, and that research is the number one role of the government.

The government is finding out, as the front page of "USA Today" pointed out, that nutrition is found to have a major impact on arthritis problems. It would be a worthy responsibility of government if research were shared and a program to transfer educational information was developed by the government.

Secondly, it seems to me that diagnosing all individuals with blood tests, urine tests, mammographies, etcetera, we would have a better understanding of the status of American health.

It would be a good thing if the Federal Government were to pay for that. Then, it might pay for a chart that each patient would receive that says, "here is where you stand. Your cholesterol is high, or your blood pressure is high, and here are some things you can do about it."

In essence, what I'm suggesting is that we put the responsibility back on the individual, just as the Chinese have done.

I don't know if you're familiar with their process, but they go to an acupuncturist four times a year, whenever the seasons change. The role of the acupuncturist is to maintain their body. If they get sick, they don't pay their doctor because it is the doctor's job to keep them healthy. I think that this is an interesting approach.

I think the third approach, of course, is the safety net whereby we would provide coverage for catastrophic accidents, diseases and various genetic problems that we can't diagnose or predict in advance.

I'd like to hear some feedback on some of those ideas if I might.

Mr. ROGERS. May I just say, I would be glad for you to look at the National Leadership Commission health plan. We try to put the responsibility on the individual to get his or her health insurance coverage.

Now, you can do it from the employer and we have an encouragement for the employer to give that. The individual can pay for it, but he must have coverage.

Ms. SCHNEIDER. Right.

Mr. ROGERS. Now, up to 150 percent of poverty, we would help those people, but that is what you're talking about I think.

Ms. SCHNEIDER. Okay.

Mr. ROGERS. Now, as for preventive medicine, I think everyone agrees it has so many good things about it. The problem is when you start to pay for it, people don't see immediate results. The demands are so heavy for acute care, where you've got somebody with terrible cancer or heart attacks. The money has been going to those sorts of cases rather than spending the money for prevention. Prevention, I agree, is very important.

Ms. SCHNEIDER. Well, I think it's analogous to our energy policy. When we had the last energy crisis, just like when an individual gets sick, its a crisis. The energy policy was starting a synfuels corporation and throwing money at it. Why not start a solar bank and throw money at it. Energy conversation and energy efficiency does not have that visual impact. It is less sexy, less appealing,.

The same thing occurs with prevention, but I think that if enough of you leaders were talking about this approach, we could change the way that we deal with these problems and build a healthier country.

Mr. ROYBAL. Time has expired. The Chair recognizes Congressman Wise.

Mr. WISE. Thank you, Mr. Chairman. I appreciate the chance to participate in this hearing. The question that I'd like to ask the panel, and anyone who wants to jump in, what happens to competition? I come from a community that we have roughly 65,000. We have got two major hospital complexes.

They are happily buying lythotripters and cat-scans and whatnot. As soon as one gets one, or one gets two, then the other one feels obligated to go get it. So, the result is that we have each one with duplicating functions and with a limited base.

Now, in the free market system, ideally, the price drops as competition. We know that is not true in the health care industry. The price stays the same as each has to pay off the bonds of when to buy this. What do we do regarding that in the systems that are being talked about? I'm happy to hear anyone's ideas.

Mr. FRASER. Our plan in Congress we would call for a State budget, but you're absolutely correct. I think you put your finger on the crucial problem. That is, in the health delivery system, the provider makes the decisions. So, therefore, you don't have the discipline of the marketplace and the discipline of competition.

Normally, the patient makes one decision. He or she goes to the doctor, and the doctor decides how many laboratory procedures, what drugs to prescribe, when they should go in the hospital, how long they stay in the hospital—and there is lots of studies on this I'm sure you're aware of—what surgical procedures to perform. He does it with the consent of the patient, but the patient has so much confidence in the doctor if a doctor says you need a surgical procedure, the patient agrees unless he is pretty sophisticated.

So, the system won't work, and it won't work because you don't have the competition of the marketplace, and you don't have the discipline of marketplace. The provider makes all the difference.

I said to a group the other day—can you imagine an automobile dealer, he's the provider in this case, and he makes the decision what the consumer wants. I'll guarantee you a lot of deals that I'd know you'd have an air conditioner in the normal place, and then you'd have another one in the trunk and another one on the roof because he is making—the provider is making the decision of what the consumer wants.

That is the basic flaw in the health delivery system. I repeat—the provider makes the decision rather than the consumer, and there is no discipline of the marketplace.

Mr. SCOTT. I would be pleased to give a quick perspective from the Canadian point of view. Technology is one area where we have had little trouble with control and a lot of trouble with management. That is, that the government, through its funding of hospitals—the hospitals must get permission to add major pieces of technology.

While that permission usually comes, it comes slowly, and part of the general excuse relates to proper assessment, yet we do not do a particularly good job of technology assessment before we put it in place. Then, usually, it is put in place on the basis of what the government accepts as the best ratio of population to the technology.

So, if you were to compare the availability of technology in the United States as opposed to Canada, the differences are mind boggling. We don't have nearly as much technology. It is generally controlled by the health science centers connected with the universities.

Mr. WISE. Is that a good or bad point?

Mr. SCOTT. It's a little bit of both. We certainly don't have, from our perspective—

Mr. WISE. Let me just say that—

Ms. MEYERS. —the cost of too much technology.

Mr. WISE. Sir, as a consumer and one who laments the health care system as much as anyone, I also know that when I go into that facility, I want to see dials, and machines, and digital readouts, and the most complex equipment, and want to know that I am being taken care of. Ms. Steelman?

Ms. STEELMAN. Just a brief comment. This is one of the most difficult questions in health care today—is the ownership of technology. While you suggest that competition hasn't worked and that it results in two lythotripters, in many communities it has worked in terms of the proliferation of managed care systems, of different networks, of different techniques, some of which are working better than others, but we're learning from every one of them.

There are aspects of competition that are beginning to work and are beginning to work quite well. In this country, we have several pockets where competition has been at work for decades—in California, in Minnesota, in certain isolated places.

We haven't seen lythotripters in every place there. What we have seen is a system that uses a lythotripter, or we've seen a new thing like Mayo going to Florida and opening up a clinic and doing interchanges with patients.

These pieces of competition are painful to the industry, and much of what you're suggesting continues to occur, but as the resources become less infinite, and I say less infinite rather than finite because I don't know that in this country we are ever going to make a declaration that our resources dedicated to health care are finite, any more than we are making a declaration that our resources dedicated to pro football is finite.

If we're going to make choices and making certain areas of resources finite, better everything be on the table, not just one area.

I'd like also to say that in health care, I heard an analogy a couple of days ago that is very apropos, although very harsh I'll admit. That is, that similar to drugs in Colombia, there is too much money on the table.

If everybody is grabbing at the money, if you have to have a lythotripter to grab that money, you'll go out and get a lythotripter. We do need to make some decisions about where the money is coming from and what it will go for that doesn't result in the old-fashioned CON process, which you may have had experience with, which certainly wasn't a good experience for anybody who was involved with it.

Mr. WISE. That's how we got more lythotripters. Ms. Steelman, during—at some time I'd like to follow-up on that. During the campaign, President Bush made a proposal in a debate concerning buying into Medicaid, and it caused a lot of discussion. I thought it had some merits to it, and there were also a lot of questions about cost.

I just wondered—do you see that as being any kind of—presently being a possible approach, at least in the short-term, particularly for low income working people to meet health care concerns?

Ms. Steelman. I am not a spokesperson for the Bush administration. He has very highly qualified, capable people who can fill that role at this time. I would defer to them on that precise question of today, what does the Bush administration think.

I'd like to personally indicate that the President was supportive of that policy during the campaign—that there are many improvements in Medicaid we need to discuss. One of them is how can Medicaid be expanded to other parts of the population? Should Medicaid be allowed, for example, or encouraged to subsidize employer-sponsored coverage where it is available?

Should employers who can't afford a private package for one reason or another, whether it's a high cost case on their payroll, or whatever, be able to buy their employees into Medicaid. These are questions with great implications. I think there is great potential there.

There again, the problem is money. The problem with Medicaid is purely money. To get beyond the rather routine expansions we have had in the last decade for which I thoroughly applaud Congressman Waxman's efforts, eligibility is the easy part of Medicaid. Reimbursement is difficult. Benefit packages are difficult.

We have a national chaos out there that is unbelievable, but to address any of those real problems in Medicaid, up to and including a buy-in, or a buy-out, or other creative uses of the program, you need to talk $10 billion.

Mr. Roybal. The time of the gentleman has expired.

Mr. Wise. Thank you very much.

Mr. Roybal. The Chair recognizes Mr. Bilbray.

Mr. Bilbray. Mr. Chairman, I'd like to address mainly Mr. Scott, and maybe my neighbor, Mrs. Steelman. Basically, what is the cost per patient or per person under the Canadian program per year?

Mr. Scott. Well, the numbers I referred to, Congressman, come from the OECD, which we regard as essentially correct, which was in U.S. dollars, it cost us $1,580 per person.

Mr. Bilbray. Okay. And again, every person in Canada from birth is covered under the program?

Mr. Scott. That is correct.

Mr. Bilbray. All right. Now, how is that deducted? Right out of their salaries? Or, do you do it out of the general fund?

Mr. Scott. It's widely spread. In the case of the Federal contribution, that would come right out of the tax base, both personal and corporate. That block funding given to the provinces is done on the basis of so many personal tax points returned to the province and so many corporate tax points.

The balance that is provided by the provinces can come in a whole series of ways. Initially, some provinces charge a premium—a premium which was adjusted for income and so on.

Now, there are only two provinces left doing that. Others did it through a sales tax, or at least they attributed the sales tax, as they called it a hospital tax, or—

Mr. BILBRAY. What percentage does the Federal Government pay of the entire package?

Mr. SCOTT. Currently, about 42 percent. It has been as high as 50 percent up to 1977. Then, the Federal Government, in effect, indexed its amounts to no more than inflation and basically said to the provinces, since you are running it, if you are going to let the costs run above inflation, then you are going to have to pick up the difference.

Mr. BILBRAY. Is everything covered under the Canadian program? Or, do you have deductibles?

Mr. SCOTT. It is difficult to—not everything, depending on how widely you describe health, but basically anything that you would do with a physician would be covered. Your hospitalization would be covered unless you optionally wanted to have a semi-private or a private room, in which case you would pay for that yourself, or have your private insurer pay for that.

But things like chiropractors, for example, they do get some assistance for some of their procedures, but they are not fully funded in the way your physician would be.

Mr. BILBRAY. Now, how do you cap the physicians' salaries? I understand the Canadian government pays the physician himself.

Mr. SCOTT. Well, the simple answer is we don't. We budget and then if it goes over budget, we pay the amount over budget. The way the system basically operates is that the government each year will give the insurance plan that pays the doctors a fixed increase amount which sets a sum. That sum is taken by the medical associations and redistributed by them amongst various medical procedures.

In other words, the medical associations determine how they take the block amount given to them by the provincial government.

Mr. BILBRAY. What would a GP in British Columbia—would he make the same as a GP in Ontario?

Mr. SCOTT. No. I have the numbers in here somewhere, and I would happily send them to you, but I know that the lowest average income for a physician in our provinces is about, I think, $84,000 or $85,000. The highest average income is in Ontario which is $120,000.

When I say average, that is a definitional problem, too. That could include semi-retired doctors doing very little practice and we do have some doctors who make as much as $800,000 or $900,000.

Mr. BILBRAY. On the American end now, we have the cost of about $1,580 per patient. Mrs. Steelman, or whoever it might be, what would it cost to offer the same services? Any estimate of what it would cost to offer the same services to people in the United States?

Ms. STEELMAN. No, not really. Under our current system, it would cost a lot more than that, there is no question.

Mr. BILBRAY. What does it cost us for a Medicare patient today? Do we have an average of that? A few years ago it was something like $1,250 a year per patient to provide the services. I'm sure it's twice that today, but I'm not—

Mr. SCOTT. I have the OECD figure for the United States.

Mr. BILBRAY. All right.

Mr. SCOTT. Assuming one accepts the OECD, it's $2,268.

Ms. STEELMAN. That's for—

Mr. SCOTT. For 1988.

Ms. STEELMAN. —for general population?

Mr. FRASER. I think it's running about $2,600 a year per capita right now. It is against the Canadian $1,500. And, of course, we don't cover 37 million and others have inferior health care.

Mr. BILBRAY. So, what you're saying is basically, if we offer the same sort of system or a similar system to the Canadian system, first of all, it is going to cost us almost twice as much, and we don't have any caps on the doctors' incomes or any pooling of monies to be divided amongst doctors.

So, we have a double problem facing us if we wanted to go into some sort of system like this.

Mr. FRASER. That's why you have to make a fundamental change in the system. That's where it will not do it.

Mr. BILBRAY. It's a drastic change to make. The doctors don't like to talk that way. Thank you.

Mr. GLASSER. May I add just one fact?

Mr. ROYBAL. Will you proceed.

Mr. GLASSER. That is—

Mr. ROYBAL. Will you please speak into the microphone.

Mr. GLASSER. That helps. The last estimate of physicians' income in the United States, indicated an average physician income net of $150,000 a year. This is current.

Secondly, the American Medical Association in its socioeconomic studies of 2 months ago, published a report that indicated that 11 percent of physician time is devoted to free or reduced price care.

In other words, with the passage of a comprehensive national health plan, one can start with the assumption that there would be at least that much increase in physicians' income due to the fact that all income is then compensated for in the new plan.

The only purpose I am indicating this is, if a new comprehensive plan which puts restraints on the increases in physician income were adopted, it is true the increases would be modified and lowered.

It is also true by the compensation for free and reduced care, they would be increased. The net result of this is there would not likely to be any substantial reduction and probably a continuing modest increase in physician compensation.

Mr. BILBRAY. Unless, of course, we do like the Canadian plan where you take a lump sum of money and you put it within the plan of a certain geographical area, and then they divide it up, and that's all there is, and then they have to divide it up. Except for the Canadian plan, if I understand what you told me, if they go over that, then the government makes it up and comes with a supplemental appropriation.

Mr. GLASSER. And there's a subsequent matter. The Canadian plan includes negotiations between the provinces and the Physicians Association as to the nature of the reimbursement each year so that it is not a lump plan arbitrarily decided upon. It is one agreed upon between the parties.

Mr. ROYBAL. The time of the gentleman has expired. Mr. Bilbray, the gentleman that just answered your question is Mr. Mel Glasser. I point that out for the record, and Mr. Glasser is the Executive Director of the Committee for a National Health Insurance, a Committee under Mr. Fraser.

The record will so indicate.

The Chair now recognizes for 5 minutes Mr. Duncan.

Mr. DUNCAN. Mrs. Steelman, Mrs. Schneider mentioned a minute ago people who take care of themselves having to pay for those who don't. People getting medical care, maybe, that they don't really need. There has been some attention to Medicare and Medicaid abuse, overuse of certain benefits.

Has there been any thought given to some type of system that would provide a rebate or would reward people for not using medical care? For instance, I know there are some auto insurers who rebate some of the premium if a person or an individual makes no claims. Do you know of any consideration given to something like that?

Ms. STEELMAN. Yes. Thank you very much for the opportunity. I would have mentioned this earlier, but I didn't want to overstay my welcome at the microphone.

We are obviously considering many ways to reward cost effective behavior, both on the part of the insurance plan, the Federal Government and, especially, the individual. These range from preventive care, for example, immunizations and basic diagnostics should be insurable in both public and private plans.

Two, this kind of notion, the health rebate or, perhaps, in the plan that I described, we would lower the threshold. We would lower the catastrophic limit for a person with better health risks, reassessing that every year, so a person who did take steps to improve their health status would be rewarded, both in health rebates and other financial rewards.

Mr. DUNCAN. Thank you. Mr. Scott, I have been told that in the Canadian system, some people now are going to places such as Detroit, Boston, and New York to get treatment such as cataract surgery, heart bypass surgery, other types of medical care for which there would be long waiting periods under the Canadian system.

Also, I have been told that certain people have to wait as much as 24 hours to get treatment in an emergency room at times under the Canadian system. What can you tell us about that? Are there waiting periods under the Canadian system? Are people resorting to medical care in other locations?

I have also heard that some of the leading doctors in Canada have now chosen or are considering, at least, moving to the United States rather than to continue to operate under your system.

Mr. SCOTT. Well, to deal with the last part first, Mr. Chairman, in the case of doctors leaving, we had a very serious problem of doctors moving to the United States primarily during and following the debate over Medicare in Ontario in 1972.

That is not a problem any longer. What is, we do obviously have a considerable flow of physicians. Because of our immigration requirements, it is much easier for someone to go south than someone to come north, if they happen to be a physician because we have very strict rules regarding any physicians coming in.

I would say today that there are very few, and I can think, for example, of a couple of rather high profile examples in the last couple of years. In both of those cases, they were senior people in medical centers and moved for research reasons which is a common situation.

I am also aware of a number of research physicians who have moved from the United States to Canada in recent times. So, there is no brain drain kind of problem at all at the moment.

In the area of backups, these backups do arise from time to time, but they are usually quite limited. For example, at the moment, we do have a backup in bypass surgery in a couple of centers.

Some of that has to do with referral practices of doctors. For example, there is a backup problem in Toronto, but there is no backup problem in Kingston, 120 miles away.

So, it would be no problem if people are prepared to handle some of that by moving there. There is no question that we need to upgrade that particular area or upgrade the amount of services and the availability of the service.

It is not particularly serious in the sense that the backup is carefully streamed. It is one of the paradoxes, I guess, of our two systems, that if one person dies on a waiting list, it is the headline in the front page of the newspapers because it is an example of the breakdown of our system insofar as the media is concerned.

But, in fact, if there is only one death, it is really where the story lies. So, really there is not a serious backup of any long period, but at various times, in different areas of practice, extra resources have to be moved in, and there is always a delay period in dealing with them.

Mr. DUNCAN. Let me ask you something, Mr. Fraser. I'll go to you next. You know, a couple of nights ago, we—the Congress or the House—raised the national debt limit to $3.12 trillion, a figure that most of us can't even comprehend.

We frequently seem to ignore or overlook the fact here that our government is broke and not only broke, but very deeply in debt. That debt has increased by 3½ times just since 1980—years of relatively low inflation.

What I'm getting at is you said for the past 23 years you have been Chairman of a Committee for National Health Insurance. If we go to a completely nationalized health system where the government pays for it, how much is that going to cost, number one?

Ms. Steelman said that we are already spending, I think, $200 billion. How much is your system going to cost, number one? Number two, where is the money going to come from?

Mr. FRASER. First, Congressman, if you would allow me, because the first question you raised really puts your finger on the differences in our systems because there are these—and I live in Detroit, so I am accustomed to these anecdotal cases of Canadians coming over for heart surgery and there are, as testified, some short waiting periods.

In this country, we have 37 million people that might wait for years, might wait forever, might never get any health care. That is the essential difference in the systems.

Now, as to the cost, you have heard testimony by our Canadian visitor that said that when they initiated their form of national health insurance, we are almost equal—7 point and a fraction of our GNP. Now, they are 8.6 or thereabouts, and we are approaching 12.

It's not the question of where do you get the money. If we don't do something, it's going to be your problem. I mean, what are you going to do when we're spending 14, and 15, and God knows how far up the ladder on health care.

So, what we're saying is, if you follow a comprehensive plan, a plan that is well-designed, you are going to ease the burden that you are talking about, not exacerbate it.

Mr. ROYBAL. The gentleman's time has expired. We'll go back now to the 10-minute rule. Mr. Rogers, you probably remember that each Member had 10 minutes of questioning. I haven't used my 5. I'll try to use only 10 in the questions that I have.

Mr. Rogers, I was very interested and very impressed with your presentation, particularly when it dealt with the matter of cost. You took the position that we must improve the quality of care. We agree with that. But then, you also recommended that we do away with unnecessary procedures, then pointed out these unnecessary procedures equal, or amount to, as much as 24 percent of the entire bill.

At the same time, you said something about malpractice insurance—the tremendous cost that that brings into the picture, and then that is part of the cost.

Now, most physicians that you talk to tell us that these procedures that seem to be unnecessary are brought about by the fact that they have an insurance policy that continues to increase and in order for them to protect themselves on any malpractice suit, they find it necessary, to go through these procedures.

What is the problem there? Can you explain how this Catch 22 situation can result?

Mr. ROGERS. Yes. That's why I say you have to address them both. You can't just try to do one and not do something about the other. For instance, we think, and we looked at this in great detail, and the medical profession now agrees that we need to do research on the actual procedures that doctors do—clinical procedures—when you go in to have an operation or whatever it may be, most of those procedures have never been really researched or analyzed to know what the outcome is going to be, whether it's worth doing or not.

The prostotecramies—we're still doing thousands of those, and we still don't know if the procedure really is best. When Wennberg did his study, it showed that there were more deaths than the doctors ever realized. They weren't having the proper outcomes. It didn't change the life span. So, when he did tell the doctors in that particular State, those procedures dropped 15 percent right off.

What we're saying is you need research on these procedures. Seventy percent of the procedures done account for about 50 percent of the costs—70 alone. Think of the potential savings if you do the research and give the medical profession, and they will have helped do the research, so they accept it, some guidelines on what they should do.

In other words, what are the conditions when a person should have a prostotechamy? Those guidelines would be set forth, and you would begin, then, to aid the profession. It would be an aid to doctors. Also, it will help in the malpractice problem in that it is a nationally recognized approach.

Mr. ROYBAL. I'm sorry. Ms. Steelman is not here at the moment. She, I understand, had to leave. I was also impressed with something she said with regard to the "USHealth Plan." Here she comes. She's coming back, so I'll wait.

Ms. Steelman, I was making reference to your statement with regard to the "USHealth Plan," in which you said in very general terms, not really agreeing nor disagreeing, but nevertheless more pro than anti, that the funding mechanism was very difficult, very complex, and I agree.

I would like to have you make recommendations in writing to us as to how that can be improved. If you have any comments at the moment that you can make briefly—I understand the complexity of this situation. If you have a comment, the Committee will hear it at this time. I am asking that you, in writing, tell me this is what you think we should look at and we should be doing. Because as I heard the testimony of each one of you, I said to myself, wouldn't it be wonderful if these people could get together and draft a plan and submit it to me.

Not that I want to get away from doing any work, but it seems to me that that would be at least a recommendation that would have the approval beforehand of experts in the field. I'm not asking that you do this, but think about it.

Ms. Steelman, do you have any comment?

Ms. STEELMAN. I'll be happy to respond in writing. I know there are many other issues that people want to talk about.

Mr. ROYBAL. Thank you. Now, Mr. Fraser, I'd like to mention something that you brought out. You brought out the fact that 89 percent of the people of the United States are dissatisfied with their present plan, and I agree with you. I think that when that study was made, it was quite accurate.

But one of the things that I did not and had not realized existed is the fact that the cost of health care in the auto industry is $5,000 per worker. That translates into $700 per car which means that every time we buy cars, we provide that $700.

The increase, then, is in the price of a car. Now, the cost has to be borne somewhere, and has to be across the board. How else can we bring about cost containment and the distribution of costs if it is not broadly applied to all segments, assuming that the cost of health care in the auto industry is fair?

Mr. FRASER. Well, we don't believe the cost is fair. We think it is out of control, and we can't control it. Mr. Chairman, in every negotiations in the last 12 years, we recognized the burden placed on the company. It affects our jobs because as I pointed to this $700, it affects our competitive position, vis-a-vis the Japanese, the Germans, and so forth.

We have made several approaches with the companies. Let me give you an example where we actually drove the cost down. In 1983, we agreed, the corporation with the union—all the companies, GM, Ford and Chrysler—and we said before anybody is admit-ted to the hospital, there has to be a predetermination on nonemergency cases. Emergency cases you don't bother, but on nonemergency cases—you had a panel of doctors.

The attending doctor would have to get approval for hospital admission from this panel of doctors. What we never said is that nobody was ever refused. It had what we call a central effect.

The very fact that this doctor knew that other doctors were looking over his shoulder, it drove down the admissions to the hospital, and we had an actual decline for the first time in history, I guess, of hospital costs.

In this system as you squeezed the balloon in one place, then it pops out the other. So, what did they do? They found a way and they have the out-patient costs, the out-patient procedures went through the ceiling. So, everything we tried to do in good faith with the companies—this is why the companies are throwing up their hands. They don't know what to do anymore.

The only way it can get controls, is in a fashion that you suggest in your bill, or in the fashion that we suggest in ours, or look at the Canadian model.

Mr. ROYBAL. Mr. Scott, you said in your statement on page 3, and it is something that I compliment you for and appreciate that the Canadian Medicare model is popular and successful. You also went on to say that it does not mean that it is the answer for the United States.

We agree totally with you. It may not be the answer for the United States, but the truth of the matter is that the cost in the United States for our system is 44 percent higher than that of Canada.

You go on to state that the system has a clear mixture of elements of public and private participation, which is something that we're striving to get, and it seems to me that what you're telling the Committee is that one of the reasons for this reduction in cost versus that in the United States, is the fact that there is a clear mixture of element of public and private participation.

Is my assumption correct?

Mr. SCOTT. To a certain degree, it is, Mr. Chairman. There is no question that the mixture is very important. I certainly believe, and I think most Canadians would believe, that if we tried to have the government directly running the bulk of these services, then they would rapidly become far less efficient.

So, we regard the private sector involvement as important. Even our hospitals get a global fund, but basically those hospitals are independent, non-profit corporations with their own Boards of Directors selected in the community, not by the government.

So, we regard that mixture as very key. Our doctors, for example, on the question of whether our doctors would want to emigrate to the United States—today they, frankly, have more freedom in their practice of medicine than is the case here given the requirements of insurance companies here and others—insurance companies, Medicare, and Medicaid—the paperwork that a physician has to go through here is quite considerable, and is virtually non-existent, for example, in Canada.

So, there is a lot of freedom amongst the doctors. They make more money, depending on how hard they work. So, that mixture is important. However, I would say the other important factor is that the government does finally control the purse strings, and this is a very important element to enforcing institutions, in particular, to work pretty close to the line in terms of the way they perform as businesses or business institutions.

Mr. ROYBAL. Thank you. The matter of cost, of course, is of main interest, and is a key factor in anything that we may be doing.

I am particularly interested in the differences in the cost of care for that of the United States versus that of Canada or any other country. For example, 8.5 percent of the Gross National Product of Canada is used for their coverage. Ours is 11 percent, and it is predicted that by the year 2000, which is not too far away, it will be closer to 15 percent.

What was of interest to me, Mr. Scott, was the fact that you pointed out that just 20 years ago, your cost was 7.4 percent of your Gross National Product, and that of the United States was 7.6 percent.

It was almost similar then, but 20 years later, you are doing much better than we are. So, the question that comes to mind is, what can we do so that we can spend a percentage of our Gross National Product, which is fair and proper, and what is that percentage?

Now, I have in my bill 12 percent. It is now 11.4 percent. So, the question is, can the combined intelligence of experts in the United States actually come up with a program of some kind that can peg costs at 12 to 121/2 percent of the Gross National Product and make it stick over a period of several decades? What do you think about that, Mr. Rogers? Can that be done?

Mr. ROGERS. I think it will be difficult for us because we haven't gotten into a system where we are really controlling costs very well, yet, as Doug Fraser said, when we tried to control in-patient the out-patient cost rose—the balloon effect. So, we really haven't gotten a system to do that.

Now, I think it is possible for us if we take certain steps and reorganize the system in an overall manner, that we can begin to cut costs. For instance, we tried to set some out, and others have suggested things that could possibly be done. You, in your bill, have some.

I think if we begin to do certain things, like the quality, getting that right off, that is going to help. When we do the negotiation in the States between the payers and the medical profession—that will help reduce costs.

The Canadian plan, in fact, uses that. They just add a cap. But another thing I think we need to do, Mr. Chairman, is also an education program with the public in a number of regards. Preventive medicine is one. The greatest costs of health care occur at the beginning of life and at the end of life.

We are already starting an education program to try to get people to execute living wills, to say, I don't want to be kept alive if I'm not going to recover. If I have a fatal disease—I don't want to be just kept alive. Those costs are just astronomical.

I think it is going to take all of these things, but I think it is possible.

Mr. FRASER. Mr. Chairman—

Mr. ROYBAL. Mr. Fraser, I want to ask the same question of you and also Ms. Steelman giving each of you 1 minute for an answer. Then I ask you to submit any further remarks you may have in writing. This Committee's hearing record will be open for 2 weeks. Then, after that time, we'll close the file.

We will provide a transcript and submit that transcript to each one of you. I will have one question for each of you to answer in writing. We may have the answer partially, but an elaboration would be very helpful. Mr. Fraser, for 1 minute.

Mr. FRASER. In response to your last question, Mr. Chairman, our plan, as you will see, and I didn't articulate it because I was condensing my remarks, but in our plan, what we say—after the plan is in place, we would not allow any increases that exceeded the growth of GNP.

That would be the ceiling each year, so while it allows increased expenditures, those increased expenditures could not exceed the growth in GNP for any 1 year.

Mr. ROYBAL. Ms. Steelman?

Ms. STEELMAN. Most of this I think I'll have to do in writing, but I'd like to be a little bit of the iconoclast here. If we are not going to fully regulate our economy and say that a certain percent of our resources should be devoted to every sector of it, a certain percent, perhaps, devoted to the making of cars, and a certain percent devoted to the education of our children, and a certain percent devoted to our utilities, then it doesn't seem to me to make much sense to try to do that in health care.

Mr. ROYBAL. I'm sorry, I have to hurry you. There is a roll call, and I only have 5 minutes left before I will be considered absent.

I would like to thank you for your testimony this morning. It has been most helpful. I will repeat that I will submit one question to you and would like to have your answer.

Members of my staff will contact you personally, to see if together we can come up with some solution. There is a solution I am sure, and I think that if we work together, we can come up with that solution.

I thank you very much, and this hearing is now adjourned.

[Whereupon, at 11:50 a.m., the hearing was adjourned.]

APPENDIX

PREPARED STATEMENT OF ERIC SHULMAN, LEGISLATIVE DIRECTOR OF THE NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, Committee Members, thank you very much for allowing us to testify before you today. I'm Eric Shulman, Legislative Director of the National Council of Senior Citizens.

It would not be understating the enormity of America's health care crisis to suggest that our "system," such as it is, is in disarray. The costs being borne by consumers, industry and government are breaking our backs.

Since 1980, national spending for health care services has doubled--from $240 billion to over $500 billion a year. Of that $500 billion, consumers are paying one-fourth out of their own pockets.

Health care costs are out of control and we are all feeling the pinch.

Over 50 million Americans are either uninsured or under insured. Workers are seeing more and more of their paychecks going to pay for health care. The elderly are seeing their out-of-pocket payments skyrocket. In fact, seniors are paying the same percentage of their total health care costs as they did before the passage of Medicare. Medicare is simply filling the same gap that was filled by private insurance for those who had it, back in 1965. With medical inflation, however, older Americans are paying a larger portion of their income for health care. In 1980, seniors paid 13 percent of their income on health care; in 1988, they paid 18 percent. American industrial giants in the auto, steel, and communications industry are waking up to the impact of [illegible] health care costs on their bottom line. Yet, for all our [illegible] of the growing dimension of the problem, our solutions have been so limited in scope they do little more than put "band-aids" over hemorrhaging wounds.

The evidence is unassailable--piecemeal reform does not work. Our health care system is like a balloon, squeeze in one place and it will expand some place else. We pass a hospital prospective reimbursement program and physician costs go through the roof. Now Congress is considering Medicare limits on physicians' costs--something which we strongly support since Medicare costs alone have risen more than 14 percent annually in eight out of the last nine years--but, no doubt, doctors will figure a way around it. Witness the response of physicians to the recent Medicare reimbursement reductions--they simply increased the numbers of visits and tests to maintain their income levels. Every day laboratories perform 40 million tests. That's enough tests to provide every American with one test every six days. Doctors can "game" the system with the best of them.

Even more disturbing is our high rate of infant mortality. In any study, the United States consistently falls beneath all other industrialized nations. This decay is even more prevalent for non-whites. A black baby born in Detroit has a smaller chance of surviving its first year than a baby born in Costa Rica. Americans should be ashamed and angry about this, and they are. In Canada, 98 percent of women receive prenatal care. Only 75 percent of American women ever do. This also drives up our medical inflation. Premature and sick babies cost thousands of dollars a day. Yet many of these babies' problems could have been prevented with adequate prenatal care. All while 300,000 hospitals beds a day go unfilled. Fortunately, expanded Medicaid coverage for pregnant women and infants was one of the apparent survivors in the Catastrophic crash.

Other industrialized nations have higher life expectancies and lower infant mortality rates, even as they spend less money on a per-capita basis. Americans spend about $2,000 a year medical costs, while Europeans spend only about $1,000 to $1,200 a year. This is especially true since other countries are able to contain costs and aren't suffering the 15 to 20 percent medical inflation a year like the United States. Also, in the U.S, 23 percent of our health costs go to administration, in Canada, 13 percent. Mr. Chairman, if all we did was to lower our administrative costs to 13 percent, we would save, as a nation, about $50 billion a year; enough money to provide health insurance for every American currently without it. Plus, hospital administrators are increasing four times faster than physicians. Clearly, the United States is paying more, and getting less.

The National Council of Senior Citizens and its members are convinced that fundamental, systemic reform of the way we provide health care in the U.S. is essential and that we must begin the process now. We must burst the health care balloon and put in its place a more equitable, more efficient and more affordable national health care program. As you have no doubt heard many times, we along with South Africa are the only two nations of the western industrialized world that have not adopted some form of national health program. Yet, such a program can ensure that all Americans have access to decent quality, affordable health care. What are we waiting for?

Polls show that 61 percent of Americans favor the Canadian model for a National Health Care System. This model, while not perfect, is extremely popular among Canadian citizens--only three percent of Canadians say they would return to a U.S.-style system. Eighty-nine percent of Americans say our health care system needs fundamental change or complete rebuilding.

The cost of health care in Canada is much lower than in the U.S., with Canadians paying only 8.6 percent of G.N.P., while the U.S. pays 11 percent.

Many critics of a proposed American national health care system raise the specter of "rationing." Yet, we in the U.S. ration care as much as they do in Canada. Theirs is a rationing system based on need, ours is one based on wealth. Even for those lucky enough to be covered by one of the nation's 1,500 health insurance programs, health care is rationed, with large, profit-minded companies deciding what care is to be provided and what care people can do without. Even if coverage is provided, many companies still require patients to pay a great deal of costs out of their own pocket.

In Canada, everyone is given health care regardless of his or her ability to pay. Costs are kept down by the national government controlling how much doctors can charge and hospitals can spend. Standards are kept high by the Federal Ministry of Health and local governments which oversee day-to-day operations. Plus, patients are still free to choose their physicians and doctors are privately employed. And Canadian physicians are still well-paid, earning five times what an industrial worker makes.

One argument often levelled against the Canadian system is that it limits access to exotic medicine and non-emergency surgery. Let's face it: high-tech medicine is expensive. Yet, in the U.S., hospitals and clinics routinely buy CT scanners, MRIs and other extremely expensive medical equipment. Such equipment is either under utilized or used unnecessarily (i.e., using an MRI scan for a broken bone). These unnecessary costs then continue to fuel the fires of medical inflation.

The Swedes have solved the exotic technology problem without undue hardship by establishing six high-tech regional centers (one center for about every million and a quarter people). Problems that cannot be handled at a local level are referred to these centers. Indeed, this is how some planning problems are handled in the U.S. with some facilities concentrating on burn victims, others on heart attacks, cancer, or stroke for example. Clearly, we should examine all of our options before choosing what is right for us. But I do not, and cannot, believe that we cannot solve this problem.

Unfortunately, efforts to move toward a national health care system continue to be blocked by most medical groups, particularly by the powerful American Medical Association which gave over $3 million to political candidates in the last election. The AMA, which opposed the passage of Medicare, and now pays for full-page ads in major newspapers claiming their support, says that any changes to a more equitable system would result in poorer care and rationed medicine. But health care is already rationed in this country. If you cannot afford insurance or your insurance doesn't cover a particular procedure, then the odds are you aren't going to receive the care you need. If, as we have said, access to health care is to be rationed, it should be rationed on the basis of need, not on the ability to pay.

Mr. Chairman, you and other members of the Committee may have wondered why the National Council is testifying before you today on providing universal access rather than at the long-term care hearing held a couple of weeks ago. The answer is quite simple. While NCSC feels that long-term care is an essential need for many older people--and young people as well--we have learned a painful lesson about piecemeal reform in the Catastrophic Health Insurance saga. We must adopt a long-term care program, but it should be as a part of an overall national health care program.

NCSC wants universal health care for our grandmothers and grandfathers who may need to enter a nursing home. We want it for our fathers and mothers struggling through a devastating illness. We want it for our disabled brothers and sisters who need long-term care. We want it for our sons and daughters so they don't need to worry about the high cost of health insurance as they move away from home for the first time. And most of all, Mr. Chairman, we want for our grandsons and granddaughters. We want them born healthy so that they can live the lives their parents and grandparents envision for them.

Mr. Chairman, the inevitable force of change is coming. Just as the campaign for Medicare began after a long period of neglect for the health of our people, the time for America to enact a universal, comprehensive national health care program may be in sight. The NCSC Executive Board has adopted the following ten-point program in order to establish a basic set of principles for developing national health care legislation. We offer these principles to you and we urge you to consider them carefully as you move forward.

1) Universal Access

Under the program, every American will be covered, regardless of ability to pay. Basic health protection must be considered a right and the program must clearly establish this principle.

2) Comprehensive Benefits

In addition to protection for hospitalization and physician services, the program must cover all medically necessary health and preventive services, long-term institutional and home health care, and other essential health services.

3) Financing

Any system of financing a new national health care program must be broad-based and progressive, based upon our nation's traditional approach to financing social insurance programs.

4) Cost Sharing

Cost-sharing requirements on beneficiaries must not create economic barriers to receiving adequate health care. Deductibles and co-payments penalize the sick and therefore should not be relied upon as sources of financial support for the program. All physicians would be required to accept assignment and would not be allowed to pass along additional fees to beneficiaries.

5) Quality Assurance

Standards would be established to govern patient care in all medical settings. Independent oversight of the medical profession and peer-review organizations would monitor the quality of all medical care. Physicians, nurses and other health care professionals who have demonstrated a commitment to providing the highest quality care should be recognized and rewarded.

6) Cost Containment

A system of budgeting for all health care services would be established and adhered to in determining payment policies to service providers. Prospective hospital budgeting and a national physicians' fee schedule coupled with expenditure targets and negotiated on an annual basis will act to control health care costs.

7) Health Planning

Resources for capital expenditures on new construction and rehabilitation of existing facilities would be allocated on the basis of local, state and regional needs for additional health care services. This will ensure that the health care needs of all our citizens will be considered in determining spending patterns for the new technologies and services.

8) Patients' Rights

Patients must be treated in a timely manner and with compassion and decency and a patient-grievance procedure must be established. The burden of seeking reimbursement for services rendered should fall on the health provider and not the patient.

9) Program Administration

The national health program will be administered in such a way as to assure a strong role for the Federal government and the states. In addition, health care consumers must have the right to participate in the administrative and policy-making decisions at all levels of government.

10) Role of Private Insurance Carriers

The role of private insurance in a national health program will have to be carefully scrutinized. Insurance carriers will only be allowed to participate in the program if they meet minimum established standards for cost-effective administration and responsiveness to consumer needs. This will be essential to keeping overall program costs down, since insurance company profits and high administrative costs contribute greatly to runaway health cost.

National health care is needed now. The time is right. A large majority of Americans support such a program. Polls show that a majority of physicians actually support national health care and corporate America is showing increasing signs of support. This country should not allow another child to die because the parents do not have the money to buy insurance, another pregnant woman should not be turned away from an emergency room because that hospital doesn't accept Medicaid patients. Another senior citizen must not be forced to impoverish herself or himself because of a need for constant care. And most of all, Mr. Chairman, sick people should not have to wait until they're forced into an emergency room to receive the care they need. Preventive care saves lives and money. As you have all seen, the political will exists outside of Washington to establish a national health care program. How long do we have to wait for it?

HARVARD MEDICAL SCHOOL

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November 9, 1989

Gary Christopherson
House Aging Committee
Room 712
House Annex 1
Washington, DC 20515

Dear Mr. Christopherson:

Enclosed please find our testimony for your committee. Please keep us informed of the committee's work.

Sincerely,

S Woolhandler MD

Steffie Woolhandler, M.D.

SW:dqb

A National Health Program: Solution to the Health Care Crisis

Steffie Woolhandler, M.D. and David U. Himmelstein, M.D.
for Physicians for a National Health Program

ALMOST EVERYONE AGREES that U.S. health care is in crisis. Conservatives tend to focus on the problem of skyrocketing health costs, while liberals concentrate on the 37 million Americans who are uninsured and often denied access to care. Both sides perceive the goals of cost control and improved access as irreconcilable. In this paper we review evidence that recent policy initiatives have exacerbated both problems and fostered bureaucratic domination of medical care. We argue that a national health program (NHP) incorporating key features of the Canadian system can simultaneously improve access, contain costs, and reverse the trend toward bureaucratization.

ACCESS IN THE EIGHTIES

The U.S. has the world's most technologically advanced and expensive health care system (1). Yet we are the only developed country other than South Africa which fails to guarantee all citizens access to medical care. For about 15 years, from the start-up of Medicaid and Medicare until the early 1980s, access to care, morbidity and mortality steadily improved, but costs soared. Between 1965 and 1980 the proportion of black women receiving early prenatal care increased 50 percent; the number of poor people who hadn't seen a physician in more than two years was halved; and the proportion of health care costs paid out-of-pocket declined from 52 percent to 28 percent (2). Meanwhile, the infant mortality rate fell 4.6 percent per year, and overall death rates decreased 21 percent (2,3). Unfortunately, during those 15 years real per capita health spending (corrected for inflation) doubled (2).

Since 1980 government and corporate policies have given priority to slowing cost increases. While these policies have yet to contain costs, their toll has already been high in terms of restrictions on care and inequalities in health. Decades of steady social and health progress have been halted, and in some cases, reversed.

Access to care is worst for the poor who are least likely to be insured and most in need of services. As the ranks of the poor have swelled (4,5), the number of people without private health insurance has increased dramatically - 47 percent between 1980 and 1985 (6). At the same time the proportion of poor families covered by Medicaid dropped from two thirds 10 years ago to 46 percent in 1985 (7) as the average income eligibility standard fell from 55 percent to 47 percent of the poverty line (8). As a consequence, the number of people without health insurance increased more than 40 percent between 1978 and 1986 to 37 million (9-11), including 9.5 million women of childbearing age (12). Fifty-four percent of the uninsured live in families headed by a full time worker (9), and 13.5 percent of all employed persons are uninsured (10). In 1984, 12 million workers earning less than $10,000 per year had no health insurance (9), nor did nearly one third of all students over the age of 18 and more than a third of the poor (10).

For those with some insurance, gaps in coverage, deductibles and co-payments may still impede access. For instance, 5 million women age 15-44 have private policies that don't cover maternity care (12). More than 20 million people have health insurance so inadequate that a major illness would cause financial ruin (13). The elderly are particularly vulnerable since Medicare pays only 49 percent of their medical expenses (14), about the same proportion covered by insurance before Medicare's enactment. Today the elderly spend 15 percent of their income on health care, while low income elderly devote one quarter of total income to health care (15).

The number of under-insured, like the number of uninsured, is rising. Many employers anxious to limit benefit costs have reduced the comprehensiveness of private health insurance coverage and/or increased co-payments (16). Between 1985 and 1986 alone, the Medicare first day deductible for each hospitalization rose 23 percent, largely due to the DRG program, and over the past decade Medicare co-payments have risen 50 percent faster than the elderly's incomes (15). Many states have severely constrained Medicaid patients' choice of providers through "managed care" initiatives (17) - despite evidence from a large, randomized controlled trial that the health of the sick poor deteriorates in HMOs (18). Overall, for the first time in 50 years the proportion of health costs paid by insurance is declining, and the proportion paid out-of-pocket is rising (19).

These dry insurance statistics have very real and distressing human consequences - elderly patients foregoing vital medications because Medicare doesn't cover outpatient prescriptions; urgent surgery delayed until "insurance problems" can be cleared up; patients "lost to follow-up", at least partly because of the costs of care. A million families are denied care annually when they are sick because they cannot pay; 18 million more experience financial difficulty in obtaining care (12). Half of the families dropped from Medicaid in the early 1980s were left without insurance coverage (8). Their use of inpatient services dropped 71 percent, while their physician visits declined 38 percent (8). The most dramatic consequences of a "negative wallet biopsy" are seen in public hospital emergency rooms where thousands of uninsured patients are "dumped" each year from private hospitals unwilling to provide uncompensated care (21-23). Many of these transferred patients suffer shocking neglect.

Inadequate insurance coverage combined with funding cuts for public health programs has also undermined prevention. After decades of steady improvement, the proportion of pregnant women receiving prenatal care during the first trimester has stagnated since 1980 at 62 percent among blacks and 79 percent among whites (24). For teenagers early prenatal care rates are even lower (25,26). Among children less than 2 years old, 10 percent of blacks and 16 percent of hispanics haven't seen a doctor in more than a year (7). Forty percent of children age 1 to 4 years, and 80 percent of minority toddlers have not received a full series of vaccinations (27). Half of people with a diastolic blood pressure greater than 105 have not seen a doctor within the past year, and two-thirds of all hypertensives are poorly controlled (28), in many cases because they cannot afford medications (29). Half of all women have not had a breast exam within the past year, and one in five has not had a Pap test for at least five years (30) - often because of lack of health insurance (31). Nearly 20 percent of people with serious or chronic illnesses had no physician visit in 1986, and overall the proportion of people without a physician visit increased 70 percent from 1982 to 1986 (20). Forty-three million Americans could identify no regular source of care in 1986, an increase of 65 percent over 1982 (20).

These barriers to access and inadequacies in prevention almost certainly contribute to the United States' poor record on infant mortality, life expectancy and other measures of health status. For instance, a recent 118 percent increase in reported measles cases signals that falling immunization rates have begun to take their toll (32). Despite our vast wealth, the U.S. infant mortality rate ranks only 17th lowest among nations (24,33), and the rapid improvements of the previous decade have stalled during the 1980s (2,7,24). High postneonatal and maternal mortality rates for blacks have not fallen over the past five years, after decades of steady decline (2,7,24). This data for blacks must illustrate socioeconomic as well as racial disparities, since vital statistics data are not routinely categorized by income or social class (34). Overall U.S. death rates are higher than in many other affluent countries (35), and have commenced an almost unprecedented upswing (19).

Much of the illness among minorities and the poor is due to medically preventable and treatable conditions (36-38). Most of the excess mortality among blacks is due to heart disease, strokes, cancer, diabetes, and infant mortality - things physicians can do something about. But only if the patients get to their offices.

To summarize: about one-quarter of Americans are inadequately insured, and the number has been rising; they are often denied care or are reticent in seeking it because they cannot pay; their health is worse and their death rates higher than the affluent and well insured; and our national health statistics reflect the deepening access crisis. In effect we are rationing health and health care based on ability to pay. Some form of rationing would be necessary if health resources were in short supply. But the U.S. faces a growing surplus of hospital beds and physicians (39,40). In effect, health policy has focused on "rationing the surplus", an exercise which might be comical if its consequences were less dire.

THE COST CRISIS AND THE BUREAUCRATIC SQUEEZE

Health policy in the 1980s has been characterized by a virtual obsession with cost control. An exposition of the resulting welter of programs, strategies, and incentives is beyond the scope of this paper. But a few key trends are discernible.

First, costs have not been contained (41). Expressed in constant dollars (ie. adjusted for the consumer price index), health expenditures are rising more rapidly during the 1980s than they did in the late 1970s (19,41-43). Costs continue to spiral upwards despite declining hospital occupancy rates, cuts in federal and state programs, increasing insurance co-payments, and rising HMO enrollments.

Second, most cost containment strategies have constrained clinical services through administrative limitations or financial barriers. However, the bureaucratic apparatus needed to erect, maintain and police these disincentives to care is itself extremely costly (44). Thus the Medicare DRG program has forced hospitals to spend billions on new billing computers, DRG coordinators, and other administrative appurtenances needed to assure financial survival (45,46). The risk of undercare inherent in DRGs has spawned an army of vigilant overseers (PROs), whose demands for copies of medical records has forced hospitals to spend as much as $75 million annually on photocopying alone (47). Similarly, HMOs spend large sums enforcing disincentives to care (and excluding non-members entirely), resulting in administrative costs approximating those in fee-for-service practice (48, and Willis D, Brudevold C: personal communication). By 1983 bureaucratic costs accounted for 22 percent of U.S. health spending (44), a proportion which continues to increase (49). The number of health administrators is rising three times faster than the number of physicians or other health care workers (2,50-53). In 1985 health insurance overhead alone consumed $106 per capita, as much as research, public health programs and new health facility construction combined (41).

Third, recent policies have provided incentives for health institutions to act in a more "business-like" way. Unfortunately, sound and compassionate clinical decisions sometimes lose money for a hospital or HMO. Policies that encourage a more "business-like" approach reward institutions willing to bend clinical practice to financial exigency, and thus assure administrative intrusion into clinical decision making (54-56). In this context, each institution pursuing its own "rational" interests leads to irrationality in the system as a whole. Thus research has linked increasing competition with higher hospital costs (57), longer lengths of stay for surgical procedures (58), and higher death rates (59). The fiscal laxity of the past has given way to intensive efforts by hospitals and HMOs to streamline their operations, and especially to monitor and regulate medical practice. Hospitals and HMOs are identifying high cost and low profit physicians, patients, and services. Dumping these money losers (eg. sicker patients likely to have longer lengths of stay, and the more experienced surgeons who tend to care for them (60,61)), profits individual hospitals and HMOs, but worsens the overall quality of care (62) and raises system-wide costs.

The resulting spectacle of bureaucracy gone wild occasionally reaches epic, almost comedic, proportions. Some HMOs have reportedly placed their enrollment offices on the upper floors of buildings without elevators to discourage the infirm. In our hospital, a zealous administrator fearing loss of reimbursement outlawed the occasional practice of allowing an inpatient to enjoy a holiday dinner at home with family. He sacrificed his Thanksgiving patrolling the hospital lobby, and turned back a single patient: a young woman hospitalized for anorexia nervosa.

Incentives meant to increase competition have also resulted in a sharp increase in advertising. Aggressive marketing by an insurer, HMO or hospital may increase its market share, but the costs of TV commercials, full-page newspaper ads, and "free" health-spa memberships (offered by one Boston area HMO), must ultimately be subtracted from the money available for clinical services.

The failure of cost control to date suggests that any savings from reduced clinical care have been more than offset by growth in the bureaucracy needed to "beat" and police the system. Apparently, achieving cost containment through further pursuit of current strategies will require ever more stringent financial and administrative disincentives to care, and ever greater bureaucratic domination of medical practice.

JOINING THE CANADIAN CLUB

If the failings of our health policies are widely acknowledged, the feasibility of solutions is as widely disputed. The extension of access seems to conflict with the imperatives of cost containment. Yet experience in other countries suggests that universal access to comprehensive care can be achieved at acceptable cost. Canada is a particularly useful example. Patients there face few financial barriers to care (63,64); costs are moderate (65,66); and the quality of care is comparable to that in the U.S. Moreover, until the mid 1960s the health care systems of the U.S. and Canada were quite similar.

Shortly after the passage of the U.S. Medicare and Medicaid programs, the Canadian Parliament enacted legislation offering federal matching funds for provincial health insurance plans meeting the following criteria (67):

1- Universal coverage "that does not impede . . . whether by charges made to insured persons, or otherwise; reasonable access."
2- Portability of benefits from province to province.
3- Insurance for all medically necessary services.
4- A publicly administered non-profit program.

The resulting provincial programs pay for about 90% of all hospital and medical care. Private insurance has little role since by law it can only cover services not covered by the public plans (eg. some long term and dental care). Funding comes principally from progressive taxes, though some provinces charge mandatory premiums, which really amount to a regressive form of taxation. Thus all Canadians are covered for essentially all acute care services, and payments for these services come from a single government insurance fund in each province.

Most Canadian hospitals are private, not-for-profit institutions. Each hospital receives an annual global (lump sum) budget to cover all operating expenses. Capital funds (ie. for new buildings or machines) also come from the insurance fund, but are allocated separately based on hospital requests and provincial health planning goals (68). Patients are billed only for luxury items such as elective private rooms.

Most Canadian physicians are paid fee-for-service based on fee schedules negotiated between the provincial governments and medical societies. A minority are employed in salaried positions. Physicians can bill only for their personal services, ie. they cannot be reimbursed for the costs of CT scanners or other expensive machinery in their offices, nor for the work of physicians assistants or other physician extenders. A recent law has essentially banned "balance" billing (69); physicians must accept the fees from the insurance fund as payment in full. Physicians may affiliate with any hospital willing to grant them privileges.

The Canadian system has proven extremely popular with patients (67), who have free choice of providers with virtually no out-of-pocket costs. Access to care for the poor improved dramatically with the institution of universal coverage (63,64). Most measures of health status are at least as good as the comparable U.S. figures.

Cost increases have been modest. While the U.S. and Canada devoted similar proportions of GNP to health care in the 1960s, by 1985 health care accounted for only 8.6 percent of GNP in Canada and 10.6 percent in the U.S. (19,66).

Medicine remains a desirable and prestigious profession in Canada. Indeed there are many more applicants per medical school slot than in the U.S. (4.7 vs 1.8) (70,71). Physicians have objected, often strenuously, to the elimination of balance billing and other constraints on fees. However, physician incomes are high (4.8 times the average industrial wage, similar to the U.S. figure), and income differentials between primary care and procedure oriented specialties are relatively small. There is less bureaucratic intervention in clinical practice than in the U.S., and billing is considerably simpler. Fewer than 400 physicians chose to emigrate in 1985 (72).

The Canadian approach has encountered several problems. Some providers argue that constraints on capital spending have resulted in inappropriate rationing of high technology equipment and services. Certainly expensive technologies such as CT and MRI scanners have diffused more slowly than in the U.S., and fewer coronary artery bypass operations are performed (though it is unclear whether optimal rates are closer to the Canadian or U.S.

figures). But the lengthy queues for services that have plagued the British National Health Service are not a feature of the Canadian NHP.

Fee-for-service reimbursement encourages excessive interventions, and generates pressure for cost increases from physicians and regulation from government. In the face of rigid fee controls physician visits and referrals have increased. Government has responded by limiting the total pool of money available for physician payment, and some provinces have placed caps on physicians' incomes.

The geographic maldistribution of physicians continues. In response some provinces have offered fee premiums for physicians in underserved rural areas, while British Columbia has virtually banned the establishment of new practices in over-doctored areas.

Though some provinces have introduced innovative long term care programs (73), the provision of these services remains uneven. Additional problems include insufficient preventive activities, which are reimbursed but scarcely encouraged, and the failure of the Canadian system to deploy physicians' assistants, nurse practitioners and other non-physician providers.

While a health care system cannot be transplanted from one society to another, the U.S. can learn much from Canada (74). Coverage of all provincial residents under a single program has saved billions of dollars annually by greatly simplifying billing and administration (44). The monopsony payment system also aids in cost containment by facilitating enforcement of overall spending limits (75). Public administration has proven much more efficient than private insurers. Insurance overhead consumes only 2.5 percent of funds, similar to the U.S. Medicare program but less than a third the percentage taken by private U.S. insurance firms (44).

Canada handles hospital capital allocation more efficiently than the U.S. In the U.S., capital payments are folded in with operating reimbursement, creating undesirable economic incentives. Coupling operating and capital budgets encourages undercare in prospective payment systems like DRGs since money not spent on patient care can be used for institutional expansion. Conversely, such combined budgets encourage excessive interventions in fee for service settings, since the higher charges mean higher capital payment. Combining operating and capital payments under either fee-for-service or prospective reimbursement undermines health planning since wealthy hospitals can expand while financially strapped institutions cannot - regardless of health needs. In contrast, the Canadian system of capital payments rewards neither skimping on care nor excessive intervention. It allows funds for expansion and modernization to be directed to areas of greatest need, preventing overbedding and encouraging the regionalization of services (68).

The Canadian experience also suggests that detailed administrative oversight of day-to-day clinical practice is not necessary if financial incentives for both insufficient and excessive intervention are minimized. Indeed, mounting costs in the U.S. despite increasingly stringent administrative control of medical practice may indicate that such oversight costs as much as it saves.

In summary, Canada's NHP has virtually minimized financial barriers to care at acceptable costs, while maintaining clinical standards on a par with the U.S. These apparently conflicting goals have been reconciled through a system which cuts administrative waste and cost, allows the enforcement of systemwide spending limits, and facilitates health planning.

The adoption of similar measures in the United States is fraught with political difficulty. The insurance industry will vigorously oppose the elimination of most billing, and the substitution of public for private administration. Similarly, some hospital administrators, particularly at financially successful institutions, may oppose global budgeting (which would eliminate many administrative jobs) and stringent health planning. However, about two-thirds of the American people have supported a universal, comprehensive, publicly funded and administered NHP in every opinion poll over the past twenty years (76,77). The same proportion voted in favor of the statewide NHP referendum in Massachusetts in 1986, a major impetus to that state's recently passed (though seriously flawed (78)) universal health insurance bill. Employers whose health insurance costs have been sky-rocketing also have strong reason to favor a Canadian-style NHP which would sharply cut employee benefit costs. Finally, many physicians may find a public service oriented NHP preferable to the status quo.

CONCLUSIONS

In the U.S., recent health policies have restricted access and fostered bureaucratic dominance of clinical practice. Patients are being denied health care in the face of a growing surplus of health resources. Meanwhile, costs continue to escalate despite, or perhaps because of, the growing bureaucracy charged with restricting care.

We believe that it is possible to assure all Americans free access to high quality care at acceptable cost. However, this will require an NHP which greatly streamlines administration, establishes a single source of payment for virtually all services, and encourages health planning. Such a National Health Program is technically feasible but politically difficult. Without it we will continue to wrestle with an insoluble contradiction between cost and access.

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AARP VOTE

NOV 2 1989

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November 11, 1989

Honorable Edward R. Roybal
Chairman, Select Committee on Aging
House of Representatives
Washington, D.C. 20515

RE: Your Public Hearing
on 11/9/89 Pertaining To
Comprehensive Health Care
for Everyone

Dear Congressman Roybal:

Thank you for sending notices and for inviting me to participate at your public hearing on 11/9/89. I would like very much to have been there. I need to express my views and to state the needs as I see them. It really is hi-time for us to be getting on with the establishing of a fully comprehensive Nation-wide health care program for every one.

I commend you for holding that public hearing, and I couldn't agree with you more in your comments in the narrative portion of your public announcement.

Of course we all know that the big problem is in deciding on how best to finance a good National Health Care Program. You will be hearing lots about this and receiving lots of suggestions. Enclosed herewith is a copy of a paper which I prepared titled "OPTIONS FOR HEALTH CARE FUNDING" which, I think,merits your consideration.

Also enclosed is a copy of another paper of mine, titled "MEDICARE FUNDING PROBLEMS", also stating some suggestions for your consideration.

Sincerely,

Frank Freeland

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Associate Coordinator for
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AARP/VOTE is the nonprofit, nonpartisan voter education fund of the American Association of Retired Persons designed to yield an informed electorate about matters of concern to older persons. It will neither fund nor promote individual political candidates.

"OPTIONS FOR HEALTH CARE FUNDING"

For Medicare, Long Term Care and/or National Health Care

By Frank Freeland
8/20/89

I. Continuation of Present Sources:

In the over-all funding for all health care programs, the present sources, such as for Medicare and Medicaid and for indigent health care in the States and Counties, should be continued and enhanced as much as possible, while also resorting to other sources as per the following suggestions.

This also recognizes the fact that the General Fund, with its dependence on income taxes, etc., also helps to pay for some health care costs, such as for instance its coverage of a large portion of Medicare Part B costs.

II. Other Options:

a. Premiums:

Premiums can be used, as is a common practice for health insurance policies by the private companies, and as presently used for Medicare Part B. But any new or additional health care premiums should be very modest ones, and they should be graduated in varying amounts according to peoples' incomes, also so as not to apply at all for persons in the lowest income bracket.

b. Deductibles and Co-payments:

Here also, in using deductibles and co-payments, the amounts should be modest, and they should be graduated, also in reasonable amounts, and not applied for persons in the lowest income bracket.

c. Estate and Gift Taxes:

While being mindful of the fact that, several years ago, both National and in the States, estate and gift taxes were very significantly minimized, in a general compassionary wave then sweeping the Nation; now however - due to the great and vital need for more funding for health care - it may be that we now need to restore these taxes, with the proceeds going entirely for health care. But, if that is done, then such tax should not apply until after the death of both husband and wife, when they have no further need for their estate, with this admonition applying only for the estate tax.

d. Payroll Tax:

The payrolls can be a bit further taxed, but not much more than the present applicable rate. For health care, the present 1.45% rate can be increased to 1.5%, and the present $48,000 "cap" can be eliminated so that the 1.5% rate would apply for all wages at all levels. This enhanced tax would then go a long way in providing for health care.

e. AARP Suggestions:

In its 1989 L^ong Term Care brochure and in other current literature being issued, the AARP has offered a number of valid suggestions, using comments such as:

> "To raise this money, we will need new revenue from sources such as payroll and estate taxes, modest premiums from the elderly, and beneficiary contributions in the form of deductibles and co-insurance."

III. Recommendation: A Deductible Income Tax Credit:

At present, in doing our income tax returns, a large portion of one's health care costs is excluded when summing up the allowable deductions. That provision in the law should now be changed. In view of our ever increasing health care costs, these entire costs should be allowed as income tax deductions.

MEDICARE FUNDING PROBLEMS

COMMENTS By
Frank Freeland
9/30/89

Both before and after enactment of the 1988 Medicare Catastrophic Coverage Act (MCCA), many of us have been and still are distrubed about two major Medicare funding provisions, for which some relief is sorely needed. One is the Part B premium, and the other is the new MCCA "supplemental" ("sur-tax") premium, which a lot of Seniors all over the Nation are objecting to. Let's talk about them here.

Part B Premium:

In recent years, this premium has covered 25% of our Part B Medicare costs, with 75% being paid for out of the General Fund. Due to the inefectiveness of various attempts at the controlling of health care costs; and, in fact, also due to various faulty characteristics in our health care system tending to induce or cause the soaring of health care costs, this premium (with its 25% base) has also been soaring each year. Thus, it is now intolerable for a lot of Seniors.

As a "per month" cost, this premium jumped from $6.30 in '73 to $12.20 in '83 (up by 100%!), and to $24.80 in '88 (about double again), and it soared another 12.5% to $27.90 in '89. And now, on top of that $27.90 in '89, the new MCCA law has imposed an additional $4 in '89 for a $31.90 total at present. Under present law, the $27.90 & $4 amounts are due to be esculated in future years. That isn't bad enough, so now in Congress there is a proposal to add even more to this burden starting in 1990!

Except for Medi-Cal eligibles and other Seniors in the low income levels, for whom the new Medicare law mandates that the States must "buy-in" for their Medicare coverages, this Part B premium must be paid by all Senior enrollees, regardless of their circumstances and even though most of them must also pay out hefty sums for supplemental "Medi-gap" coverages. We simply can't let it be so increased annually.

New "Supplemental" ("Sur-Tax") Premium:

While many objectors are complaining because they say "it costs too much" and "because it must be paid by the beneficiaries, rather than being imposed on the total population, as are the payroll taxes", I think they are overlooking a basic fault, which I think is more ominous than any of their reasons. With this premium being related to peoples' "income tax liabilities", it thus excludes from its applicability incomes from government bonds and other "tax-free" incomes. That isn't fair! I know that a lot of Seniors are enjoying substancial tax-free incomes and, to that extent, they are exempt from paying this premium. This must be changed!

As such a premium might logically and reasonably be based on peoples' "ability to pay", if we are to accept that hypothesis for Medicare premiums, then I say we must relate it to peoples' gross incomes from all sources, and to be garduated accordingly. This can be done, and I propose that it should be administered by the Health Care Financing Administration (HCFA) rather than by the IRS, hopefully so as to avoid the stigma of it being called a "sur-tax".

Other Proposals:

I am aware of the official AARP catastrophic program funding proposals, and I have some concerns and questions about them, which can be discussed in another paper.

I also have suggested a number of other health care funding proposals, and they are covered in another dissertation, a copy of which is available.

○